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APPENDICITIS—ITS CLINICAL ASPECTS.*

BY J. F. W. ROSS, M.D. TOR.,

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THE following clinical histories of some of my recent cases represent different phases of appendicitis:

Case No. 1. Mr. S. Operated on February 8, 1898. Never had inflammation of the bowels before. Patient was taken ill on Sunday night, February 6, with pain in the abdomen and vomiting. The pain was chiefly localized on the right side. On Monday he lay around on the lounge. I saw him on Tuesday morning, February 8, found him lying on a sofa.

* Read before the Toronto Medical Society.

On examination of the abdomen there was marked rigidity of the right abdominal muscles, tenderness on pressure midway between the anterior superior spinus process of the ilium and the notch on the under surfaces of the liver, beneath which lies the gall-bladder. The tenderness over this spot was marked. He thus had the four cardinal signs of appendicitis, namely, *rigidity of the right abdominal muscles*, *tenderness on pressure*, following an attack of *sudden*, *severe pain*, and *vomiting*. On Monday night a severe chill supervened, he shook till his teeth chattered. On Tuesday morning temperature was about 100 and pulse about 100. Face looked anxious. I advised immediate operation.

He was moved in three miles from the country to the Toronto General Hospital. At four in the afternoon, assisted by his physician, Dr. Gee, I opened the abdomen an inch and a half above Poupart's ligament by the oblique incision. Found the appendix adherent to the under surface of the liver; it was gangrenous and filled with pus, but *had not burst*. It was carefully removed in the usual way and the wound closed. No drainage tube was inserted. Patient made an excellent recovery.

On examination of the appendix I found it to be about four inches in length. At a point about an inch and a half from the tip the lumen was found constricted and the tip dilated. This dilatation was filled with very offensive grumous pus. A gangrenous condition was present and the blood vessels in the mesentery were filled with blood clot, showing complete stagnation of the circulation in the black portion. The rest of the appendix looked in a healthy condition. There was no foreign body found. (Specimen shewn).

This attack was the first from which the patient had suffered.

Case No. 2. Mr. J. Referred to me by Dr. Noble. I saw the patient during his fifth or sixth attack and advised operation. He looked pale, and told me that he had never thoroughly recovered his health after the first attack. The attacks had been coming on at short intervals of a few weeks. The curious feature in this case was that the pain was chiefly referred to the left side, so much so that a layman, a friend of the patient, was quite anxious to be admitted at the time of the operation for fear that a mistake had been made in the diagnosis.

I opened the abdomen above Poupart's ligament by the oblique incision on the right side. After considerable difficulty I found the appendix turned downwards and backwards and covered by adhesions and completely bent on itself about its middle. The tip seemed to be in a very atrophic condition as a consequence of some previous attack. It was removed in the usual way.

On examination of the specimen I found the appendix to be about two and one-half inches in length. At a point about half an inch from the tip was the site of the original perforation, the tip having been almost completely severed from the rest of the appendix. At a point one inch from the tip the appendix was found completely doubled on itself. (Specimen shewn).

Case No. 3. Mr. W. Patient had several severe attacks, very nearly lost his life in one of them. Opened the abdomen above Poupart's ligament on the right side. Found omentum adherent to cæcum and two points at which cheesy matter was to be found, one on the outer side of the cæcum and the other on its inner and lower side. The points on the outer side, when peeled off, revealed a perforation of the cæcum; this was closed. The point on the inner side was found, peeled off and the appendix was found imbedded in a mass of adhesions in the centre of this cheesy material. It was removed in the ordinary way.

On examining the appendix it was found constricted though not completely shut off towards the bowel. The end was found distended and filled with grumous pus. The mucus membrane of this cavity was thickened and granular. (Specimen shewn).

Case No. 4. Mr. H. Referred to me by Dr. Harris. Patient had several attacks of appendicitis and when I saw him first he was just recovering from an attack. The case had been diagnosed by one or two physicians as a case of tubercular peritonitis, but his attendant physician claimed that it was a case of appendicitis. We advised him to wait for two or three weeks for operation until the sub-acute peritonitis should subside.

On examination the abdomen felt as if there was a small quantity of ascitic fluid present, intestines somewhat distended with gas and the wall of the abdomen had a peculiar *far-away feeling* that is so frequently noticed in cases of tubercular peritonitis. After two or three weeks this condition changed, the abdomen became flat and localized tenderness could be distinctly made out in the right iliac region.

Opened the abdomen to the right of the right rectus muscle by the vertical incision. Found the omentum and peritoneum very much reddened, the intestines adherent with adhesions that easily broke down, as they were evidently recent. I uncoiled the folds of the small intestine and peeled out the large intestine, cæcum and ascending colon from a bed of adhesions. I removed a large and long appendix. The bleeding from the intestines was free and one coil of intestine had to be kept pressed with hot compresses while the stitches were being introduced.

On examination the appendix was found with a constriction; beyond the constriction a dilatation that was filled with pus, together with a foreign body composed of hard fecal matter. Patient made a good recovery. (Specimen lost).

Case No. 5. Mr. S. A week before I saw him the patient complained of sudden severe pain in the right iliac region. The pain continued. Temperature became elevated but the pulse was not much affected. There was no vomiting. He did not improve in his condition and the pain did not disappear; on this account I was sent for.

On examination I found tenderness on pressure midway between the anterior superior spine of the ilium and the ensiform cartilage. No definite mass could be made out under the hand and there was no marked rigidity of the right abdominal parietes. I felt satisfied, however, that there was some serious change that had taken place inside in connection with the vermiform appendix and that the patient would be safer after an operation than if left alone. I told him that he would be safer with his appendix in a bottle and that he could choose for himself. He decided to have it removed.

Operation was performed in the usual way and the appendix was found with a large pinkish tinted fat-filled mesentery freely moveable in the abdominal cavity just under the point of greatest tenderness on pressure. It was difficult to find it at first owing to the fact that it was very high up and that it curled forward in front of the cæcum, on a level with, or a little above, the navel. The fat of the mesentery had an œdematous appearance as if filled with inflammatory exudate. Appendix was removed in the usual way. Patient made an uninterrupted recovery.

On examination of the appendix it was found to contain a foreign body in the shape of hardened fecal matter. After hardening it with formaline I made an incision into the fat and found an area commencing to break down. On examination from the appendiceal side a small perforation was found leading into this fat.

Owing to the fact that the perforation had not taken place into the abdominal cavity the symptoms were not as severe as usual Had no operation been performed I am satisfied that in a short time pus would have formed in the mesentery of the appendix and that it would, in all probability, have perforated into the abdominal cavity and have given rise to the symptoms of *so-called secondary rupture.* (Specimen shewn).

Case No. 6. Mr. V. Patient suffered from several attacks of appendicitis, one of them very severe, from which he nearly lost his

life. Did not recover his health; remained pale and anæmic. A thickening could be felt before operation.

Opened the abdomen to the right of the right rectus muscle by the vertical incision. After a great deal of searching found the appendix imbedded in a mass of adhesions upwards and outwards on a level with the navel. Stripped off the adhesions and finally isolated the appendix. Removed it in the usual way. There was no pus found. Recovery.

On examining the appendix found the seat of the old perforation about three-eighths of an inch from its tip. The tip remains like a knob almost broken off. The remainder of the appendix did not show any very great change except that it was very patulous up into the intestine. (Specimen shewn).

These cases, however, will illustrate the operation of appendisectomy when performed in the earliest stage of the disease and in the interval between intermittent attacks. I have yet to lose the first case after operation performed in the interval between attacks. Some of these operations have been very difficult, involving a large amount of handling of intestines, the closure of intestinal perforations, and the clearing out of cheesy material and pus in small quantities. The success of the operation, when done early in acute cases, has also been very great. In some of the cases I have found it impossible to remove the appendix and been forced to do nothing but make an incision down over the gangrenous tissues and pack the wound with gauze. These cases have also done well.

But a different tale is to be told regarding those in which medical treatment has been relied on and the dark wall of the abdominal parietes has remained as a barrier between the eye of the observer and the pathological change within. I am tired of the so-called medicinal treatment of appendicitis. I feel satisfied that, with proper precautions, five hundred healthy appendices can be removed without a death in the hands of a skilled operator. When this is so and the four cardinal symptoms that I may again enumerate, namely, *sudden pain in the abdomen*, *vomiting*, *tenderness on pressure*, and *rigidity of the right abdominal parietes*, distinctly point, almost infallibly, to appendicitis, surely medicinal treatment should be shelved. If I myself had the four cardinal symptoms I should send for a surgeon to open my abdomen.

The *so-called secondary perforation* in my experience most frequently means *rupture of a gangrenous and distended appendix, or the rupture of an abscess in the mesentery of the appendix secondary to a perforation into the mesentery.* After rupture has taken place the

organ quickly contracts and it is impossible to say, on examining it, that it has been much distended.

Case No. 1 would have been placed beyond surgical aid in a few hours by rupture of his appendix and the discharge of the foul and poisonous contents into the peritoneal cavity. Case No. 5 would, in a few days, have been placed in a similar position by rupture of pus formed in the mesentery of the appendix from broken-down fat cells, into the general peritoneal cavity. Operation cannot be done too quickly.

I saw one patient in consultation with Dr. McKeown, at St. Michael's Hospital, and within an hour we had the patient's abdomen open. Gauze was packed around the appendix and the swollen gangrenous organ lifted up. Just as it reached the level of the skin it burst, and the grumous pus fell on the protecting gauze instead of dropping into the peritoneal cavity. The patient's life was saved.

When the public is educated by the profession to the necessity of early surgical interference, the death rate from appendicitis will be materially reduced. To hear the argument that a certain doctor has treated so many cases medicinally and that they have all recovered, indicates that he has had but slight experience. Surely such an argument is offset by the one that I might use, that I have operated on a large number of cases in the interval between attacks and that they have all recovered. This could not be fairly used to represent all of the surgical aspect of the question.

I would like to learn what medicinal treatment is in these cases, on what principles it is based, how the medicines act, and what they do. I am a great believer in the production of adhesions, in the sending forward to the front of armies of leucocytes to work their way into the enemies' country, in the protective properties of the omentum, but I am not much of a believer in the action of any medicines yet known on the poisonous toxines produced by peritonitis.

Now for a word regarding the second stage of the disease. The public have begun to call it the "*too late stage*," the stage of *neglect* and *inactivity* on the part of the physician. The question is constantly asked the surgeon, "If my son or daughter had been operated on sooner might not his or her life have been saved?" The surgeon, to protect his professional brother, says nothing to incriminate him but perhaps does not tell the whole truth. We see according to our light. But surely experience is the best teacher.

Every third-year student should be able to diagnose a case of

appendicitis. The literature of the present day is teeming with cases, and members of the medical societies are sick and tired of discussions of the subject. It is too late to call a surgeon to operate on a case after the pulse has become rapid, rupture (the so-called secondary rupture) has taken place and the whole peritoneum has become inflamed. This is not the period for operation, *the golden opportunity has slipped by.* It is owing to the fact that so many operations have been done in this stage that surgical treatment of appendicitis has been somewhat discredited. Such cases do recover with a prolonged convalescence and after hovering on the verge of the grave for days. But no such prolonged convalescence is noticed in cases operated on within twenty-four hours of the onset of the attack. These cases invariably do well if operated on by a skilled surgeon and with proper precautions.

I am willing to grant that in country districts, where the fee of a consultant from town is a considerable item to the people who have to pay it, the physician is to be excused for delay, but, in cities where skilled consultants can be obtained within an hour, where trained nurses can be had within a few minutes, where people are more willing to consent to operative interference, the delays so frequently seen are not to be so readily excused.

All that I have to say now is said after years of mature consideration and ripe experience. It depresses me to receive messages from distant towns by telephone or telegraph to come at once to operate for appendicitis and to arrive and find the patient dying after three, four or five days of illness and delay. This is a more frequent experience than that of arriving in time to operate with any hope of success.

The cases operated on in the intercurrent period between attacks nearly all come to the city for the purpose of operation. Finally, I claim that it is possible, by careful consideration of the symptoms, to make a positive diagnosis of appendicitis in its earliest stage, and that it is much safer to lift the abdominal veil to ascertain the condition present and remove the source of danger. If exploratory operation is ever a justifiable operation, when the symptoms of appendicitis are present it is doubly so.

THE SYMPTOMS AND PATHOLOGY OF SEBORRHŒIC ECZEMA.

By Graham Chambers, M.B. Tor.

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In the year 1887 Unna introduced the name seborrhœic eczema to the medical profession. He had been studying the relations of a number of diseases, such as pityriasis capitis, the seborrhœa sicca of Hebra, the seborrhœa corporis of Duhring, the lichen annulatus serpiginosus of Erasmus Wilson, as well as of certain forms of rosacea, of eczema, and of psoriasis, and had found that they were very closely allied both as regards their clinical and pathological features. He found that they were all superficial inflammations of the skin, catarrhal in nature, with an exudate which contained as a rule very little serum, but a large amount of fat. He found that the increase of fat was a result of the dermatitis, and was derived from the coil glands and not wholly from the sebaceous glands, as had been generally held. A bacteriological examination of the scales and crusts convinced him that there was invariably present in all these diseases a flasked shaped bacillus and a mulberry coccus. He found that the flask bacillus was the same as that previously isolated by Malassez, and that a pure culture of it was without effect on the skin. However, with a culture of the mulberry coccus he was able to produce an eczematous patch followed by alopecia.

These pathological relations convinced Unna that all these diseases should be classed under one head, to which he gave the name seborrhœic eczema.

As the symptoms of the eruption undergo considerable variation in different regions of the body, I shall first shortly describe the general symptoms and pathology of the disease taken as a whole, and then I shall give a description of the clinical features as they appear in different localities on the body.

General Symptoms.—Seborrhœic eczema is an infectious inflammation of the skin. It may occur on any part of the body, but it

has preferences for certain regions. It invariably commences on the scalp, whence it tends to progress downwards, affecting different localities in the following order of preference: Face and neck, sternal and intrascapular regions, groins, armpits, umbilicus, and lastly the extremities. In a few cases it becomes general, producing a form of pityriasis rubra. The disease is as a rule very sluggish in its course. It may remain confined to the scalp for years before it invades the rest of the body. When the disease spreads, widely separated localities may be attacked. Thus seborrhœic eczema of the scalp and inguinal regions is fairly common.

The lesions generally have a scaly or crusted appearance, although they frequently undergo change, as for example, into the moist form. Moist lesions are probably always secondary, and in most cases are associated with the scaly or crusted manifestations of the disease. In uncomplicated forms of the disease vesicles and pustules are absent.

The scaling lesions are the mildest variety, and are frequently seen on the scalp and face, where they form circumscribed or diffuse scaly patches, on a normal colored or slightly hyperæmic skin. This is the condition which was formerly described as pityriasis capitis, barbæ, faciei, etc. Another form of scaling lesion is seen during the involution of the crusted and papular patches, particularly in the sternal and intrascapular regions. Here the skin has a fawn color which is a specific symptom of this disease.

The crusted form of lesion results from the accumulation of scales, fat and fibrinous serum. The crusts are generally greasy and of a yellowish or brownish color. Typical forms are frequently seen on the scalps of infants and of adults, where they nearly always result in alopecia.

Besides appearing in diffuse patches the lesions frequently present very characteristic forms and figures during the evolution and involution of the disease. Thus we frequently see solid patches varying in size from a pea to a large coin. Many of these lesions clear in the centre and assume an annular form, and these again may become crescentic in shape by the involution of part of their circumferences. When a number of these annular and solid forms coalesce gyrate figures are produced. The epidermis around the periphery of many of these lesions has a wrinkled appearance. The scales and crusts are, as a rule, readily scratched off down to the tips of the papillæ, when the surface of the patch appears dotted with minute blood points. This is the condition which is so frequently observed in psoriasis. An important characteristic feature of the

disease is the fact that subjective symptoms are often absent, and never well marked. The patients are sometimes unaware of the existence of the rash until their attention is directed to it; but itching in moist regions is generally complained of, and occasionally may become severe, particularly when the patient is heated.

Pathology.—A microscopical examination of the skin shows that the disease is always a dermatitis. In a mild case such as the scaly form the inflammatory exudate is principally situated in the papillæ and around the hair follicles; while in the more severe grades it extends to part or whole of the cutis. The epidermis is always thickened and shows deficient cornification. Mitosis of the prickle cells, which is always present, is most marked in the papular and crusted lesions. The cells of the stratum corneum generally have distinct nuclei, and can be seen exfoliating from the surface, showing the epidermic origin of the scales found in this disease. There is no indication present in support of the view which was held by Hebra, Sr., that the squamæ were derived from the sebaceous glands. These latter, are, as a rule, unchanged. The sweat glands, however, frequently suffer from degeneration of the epithelial cells lining part or whole of their coils. The infundibula of the long hairs are always dilated and are completely filled with fat, horny and granular cells in the form of a conical plug which Sabourand has named "Seborrhœal cocoon." On account of their dilated mouths the hair follicles appear more hour-glass in form than normal. The hairs are atrophied and their sheaths frequently have a wrinkled appearance.

A bacteriological examination of the scales, crusts, and follicular plugs shows great numbers of bacteria, and many investigators have attempted to isolate the parasite of seborrhœa and seborrhœic eczema. As far back as 1874 Malassez in Germany, and Chincole in France isolated bacteria in connection with disease, but no inoculation tests were made. Later Unna isolated a mulberry coccus, to which he gave the monococci and with a culture of it produced alopecia in a rabbit. Inoculations on himself and on his assistant produced eczematous patches. Sabouraud in 1897 reported a method by which a pure culture of a micro-bacillus could be prepared from the scales and crusts and "seborrhœal cocoons.' Inoculations with this bacillus produced typical patches of alopecia areata. Unfortunately he did not report whether or not it would produce a dermatitis. If Sabouraud's micro-bacillus should prove to be the parasite of seborrhœic eczema, then alopecia areata will have to be considered an acute form of the disease. Merrill, of Mass-

achusetts, has also made a special study of the flora present in the scales and crusts of this disease. He has isolated ten distinct forms, two bacilli, two micrococci, and six diplococci. The micrococci were staphylococcus albus and aureus. They were invariably present on New York city patients but generally absent in country patients. Merrill found that two forms of diplococci were quite constantly present and that cultures of them had respectively a white and a yellow color. He inoculated patients with these forms and found that in the majority of cases typical eczematous patches resulted. From these lesions the same diplococci were obtained.

Regional Forms of Seborrhœic Eczema.

SCALP

The clinical features of the disease in this locality are somewhat different from those on other parts of the body. This is no doubt due to the presence of long hairs and other anatomical differences. In describing the symptoms I shall follow the classification of Unna, who divides the disease in this region into three forms:

(*a*) Pityriasis capitis.

(*b*) Eczema sehorrhœicum crustosum capitis.

(*c*) Eczema seborrhœicum madidans capitis.

These forms may occur independently, but frequently they are associated, or shade off into each other. All the forms may be followed by alopecia.

PITYRIASIS CAPITIS.

(*a*) This is a very common form of the disease, and is familiarly known as dandruff. The vertex is most frequently attacked, but it may extend to the whole of the scalp. The lesions are, as a rule, diffuse, and are covered with white or greyish furfuraceous scales. These squamæ occasionally accumulate to form patches of considerable thickness. The affected skin is generally pale and dry, but hyperæmia may occur. The hair becomes dry, brittle, lustreless, and atrophied, and in most cases gradually falls out. Pincus gave the name alopecia pityrodes to this form of baldness. Pityriasis capitis frequently extends on to the neck and forehead. In the latter position it forms a scaly or crusted band—seborrhœic corona—along the border of the hairy scalp.

ECZEMA SEBORRHŒICUM CRUSTOSUM CAPITIS.

(*b*) The clinical features of this form vary with the age of the patient. During the first year of life it is represented by the greasy, yellowish scales and crusts which are chiefly situated at the vertex, but

may be found on any part of the scalp. When the crusts are removed the scalp sometimes appears normal, while at others it is red, inflamed, and moist. With older children a similar condition may be obtained, but a weeping eczema is more frequent. At puberty and onwards the crusted form is very common, and frequently cases are observed where the whole scalp is covered with yellow or brownish-black, wax-like scales and crusts. Occasionally annular and circinate lesions occur similar to those found on the trunk. These look somewhat like ringworm, but short, broken-off hairs are never found. If allowed to take its course this form of seborrhœic eczema invariably is followed by alopecia.

ECZEMA SEBORRHŒICUM MADIDANS CAPITIS.

(*c*) Moist seborrhœic eczema of the scalp occurs principally in children. It is always secondary to the scaly or crusted forms. When all the lesions become moist in appearance the eruption very closely resembles weeping irritation eczema. The latter, however, is symmetrical, whereas there is no tendency to symmetry in the former. Again, in the seborrhœic process there is generally part of the eruption which has retained the scaly or crusted appearance. Weeping seborrhœic eczema of the scalp in children is generally associated with a similar condition on the face, ears, and forehead. Pustules and boils frequently result from the infection of the lesions by pus germs.

FACE AND NECK.

When the eruption extends to the face it selects as its favorite site the central portion—interpalpebral space, nose, chin and adjacent parts of the cheeks. This is probably due to the habitual loss of tone in the vessels of these regions. The clinical manifestations of the disease in these localities may be the same as in other parts of the body, but they frequently present a special type characterized by redness with slight scaling. Unna gives the name seborrhœic rosacea to this process and claims that nineteen out of every twenty cases of rosacea are of seborrhœic origin. This telangiectasis probably results from the chronic dermatitis in a region where the vessels are predisposed to paralysis. The bearded portion of the face and neck of man are frequently the seat of the disease. Here the clinical features are as a rule the same as on the scalp, and lesions present a scaly, crusted, or moist appearance. The disease in this locality is frequently complicated by other skin affections as for example sycosis. The seborrhœic eczema is the primary and the pus infection of the follicles the secondary affection, and therefore this form of the eruption should be called sycosiform

seborrhœic eczema. These cases were formerly classed under sycosis, and were found very intractable to treat, and when apparently cured had a great tendency to relapse. The explanation of this characteristic is probably that, although the pustules had disappeared, the seborrhœic eczema was still present and formed a good nidus for re-infection by pus germs.

The eyelids are also frequently attacked by the disease. Their external surfaces may present a red and scaly appearance, but it is generally at their borders amongst the eye-lashes that the disease is most frequently found, forming many cases of blepharitis.

The disease is also frequently seated behind the ears, where it forms red crusted or moist patches. These lesions somewhat resemble those of irritation eczema, but the former are more sharply defined and give no history of vesication. The ears are also affected by the process. Scaly patches are frequently seen in front of the conchæ and in the auditory canals.

TRUNK.

The disease in this locality is fairly common and is generally limited to the sternal and intrascapular regions. The clinical features have been known for at least the last fifty years. Its process corresponds to the lichen circumscriptus (Willan and Bateman), lichen annulatus serpiginosus (Erasmus Wilson), seborrhœa corporis (Duhring), seborrhœa papulosa (Crocker), etc. The eruption begins with red, scaly papules. These enlarge to the size of small coins when frequently their centres undergo partial involution, becoming scaly and fawn colored, which is very characteristic of this disease, These lesions increase by peripheral extension, and are bounded by slightly elevated salmon-colored papules. When several of these lesions coalesce a gyrate formed figure results. This is the origin of the flower-leaf form which is sometimes seen in these regions. Frequently part of the circumference undergoes involution and a crescentic shaped figure is produced. The solid lesions generally have a red, scaly appearance, although at times they become somewhat papular in character. The eruption is very chronic in its course. Slight itching, particularly when the patient is heated and perspiring, is the only subjective symptom complained of. When the disease attacks the umbilicus the lesions are apt to become inflamed and approach in appearance non-seborrhœic eczema. The scales and crusts are greasy in character. Until quite recently it was held that many cases of eczema of the umbilicus were due to the irritation of rancid fat, a product of an antecedent seborrhœa.

Now the order has changed, and the seborrhœic parasite is believed to be the cause, and the secretion of fat the result of the inflammation.

GROINS AND ARMPITS.

The lesions in these localities are as a rule sharply defined and irregular in outline. The centrally healing, centrifugally extending type is the most common form. However, solid particles with polycyclic borders are frequently observed. In the inguinal regions the writer has seen several cases where the lesions had an irregular convex papular border extending on to the thigh and lower part of the abdomen, and bounding a highly glazed red surface. This centrally situated part of the lesion has sometimes the typical fawn color. These cases were formerly classed with the so-called eczema marginatum. The disease was formerly frequently diagnosed as intertrigo. The lesions of the latter are poorly defined, are not bounded by irregular lines, and do not extend beyond those parts where the natural folds come in contact with one another. Owing to the excessive moisture present and the constant irritation of the folds of the skin in these regions the parts frequently become inflamed and weeping, and then scaling and crusting are not observed. However, as soon as the lesion extends beyond the region of excessive moisture, then it becomes dry and covered with scales and crusts.

The symptoms of the disease in the axillæ are very similar to those in the groins. The lesions occur in various forms—nummular, annular, circinate, gyrate, etc. Itching is frequently a marked symptom in both localities.

EXTREMITIES.

When the disease attacks these regions the lesions are, as a rule, not so characteristic and well defined as those on other parts of the body, and consequently the eruption becomes difficult to diagnose, unless well-marked objective symptoms occur on other localities. The solid, scaly and crusted lesions are the most commmon forms, while the annular and crescentic types are rarely observed. The solid lesions may unite and form a continuous surface of considerable size; but there is invariably some small solid lesions separated from the main patch. The writer has observed several such cases over the shins and around the ankles of patients. The palms and soles were also attacked by the disease. In these regions slightly scaling patches were generally observed.

COLLES' FRACTURE.*

By R. Ferguson, M.A., M.D.,

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COLLES' fracture is said to be the most frequent of all fractures except that of the clavicle. The general practitioner, as well as the specialist in surgery, often has occasion or opportunity to treat this fracture. It is, however, one of the most difficult to reduce satisfactorily, and in probably no other do deformity and impaired function so frequently result, either from improper treatment or unavoidable causes. It is a prolific source of malpractice suits, and the bane alike of the experienced surgeon and the bungling tyro.

Colles' fracture, so-called from the eminent Dublin surgeon, who, in 1814, first described the nature of the injury, is a fracture of the lower end of the radius, about an inch above the articulation, at the junction of the compact with the cancellated bony tissue. It extends higher upon the posterior than the anterior surface, as it is usually oblique from before backwards. The external lateral ligament is almost invariably ruptured, and the radio-ulnar ligaments are also frequently ruptured. The styloid process of the ulna is often fractured.

This injury is nearly always caused by a fall on the palm of the outstretched hand, the whole weight of the body being transmitted through the radial side of the hand to the lower end of the radius. The lower end of the ulna being excluded from the wrist-joint by the interposition of the inter-articular fibro-cartilage, does not suffer from the impact of the fall, with the exception of the internal lateral ligament, which is usually torn.

The deformity and its causes. This fracture has been called the "silver-fork-fracture," but the resemblance holds only when a side-view of the fracture is taken, and does not apply to the dorsal view, in which the most striking deformity of the fracture, viz., the dis-

*Read before the London Medical Association, March 14th, 1898.

placement of the hand to the radial side, is outlined. The well-marked dorsal prominence is caused by the displacement of the lower fragment upwards and backwards by the action of the radial extensors of the carpus, the extensors of the thumb and the supinator longus. The prominence on the anterior aspect, caused by the projection forward of the lower end of the upper fragment, is held to be due to the action of the pronator quadratus and the pronator radii teres. The hand is displaced to the radial side, so that its axis is oblique to that of the forearm, and the head of the ulna is unduly prominent. The displacement of the hand is accounted for by the direction of the fracturing force; the ulnar border coming first into contact with the ground, the force is directed towards the radial side as well as upwards and backwards. This same force almost invariably tears the internal lateral ligament from its attachment to the styloid process of the ulna, or fractures that process itself. The prominence of the head of the ulna is not due to displacement of that bone, but to the hand being shifted to the radial side and away from the ulna.

Treatment. A great many forms of splints and appliances have been devised for the treatment of this fracture, but a complete reduction of the displacement is of more importance than the form of the appliance used. Bad results are usually due to incomplete reduction rather than to unsuitable splint appliances.

The fracture, if reduced, has no tendency to separate. Strong dorsal flexion, forcible extension, counter-extension, and manipulation are required to disentangle the fragments and remove the dorsal prominence. This is best done under an anæsthetic, and untoward results would be less frequent if the rule of reduction under an anæsthesia were more generally followed. If properly reduced, a straight line through the middle of the index finger will touch the outer edge of the styloid process of the radius. Impaction of the upper fragment into the lower occurs frequently in this injury. The compact tissue of the posterior aspect of the upper fragment is impacted with the cancellous tissue of the palmar aspect of the lower fragment. In feeble, aged patients reduction of the impaction is not advisable. It is better to have a deformed wrist than failure of bony union, and impaction favors the consolidation of bony union. At all events, the patient should be consulted as to the choice between permanent deformity and an attempt to reduce the deformity with the risk of non-union. In the majority of fractures, rest and fixation of the parts are the great desiderata, but not so in this fracture. Here we have to treat not simply a broken bone but a severe sprain and injury of the wrist joint as well. The treatment must be largely the

treatment of sprained and ruptured ligaments, and the replacement of bones displaced by the loss of ligamentous support. The most striking deformity of the fracture, viz., the displacement of the hand to the radial side, is due to rupture of the ligament connecting the styloid process of the ulna with the side of the carpus. Dr. Carson, of Savannah, Ga., has proved with the aid of the x-rays that we may have the characteristic deformities of Colles' fracture from rupture of this ligament alone, or fracture of the styloid process, even though the radius may be wholly intact. Further the anterior and posterior ligaments and the radio-ulnar ligaments are certain to be injured. There is also displacement of the inter-articular fibro-cartilage. More or less inflammatory action must be excited in the tendons of the hand passing through the anterior and posterior ligament. These considerations, together with the proximity of the fracture to the wrist-joint, indicate that the treatment of the sprain is of primary importance. Complete bony union is assured in three to four weeks, while ligamentous union requires a much longer time.

Whatever form of splint is used it should not extend beyond the metacarpo-phalangeal articulation. A long anterior splint conforming to the mould of the palm, and a short posterior splint reaching only to the wrist joint, are usually employed. Free movement of the fingers from the outset, to prevent fixation of the tendons, is an important precaution. Antero-posterior splints extending only to the wrist answer quite well, and are a safeguard against ankylosis of the joints. Extra padding may be used over the dorsal and anterior prominences of the radius, and over the anterior prominence of the ulna.

Dr. Pilcher, of New York, and Dr. Moore, of Rochester, were among the first to advocate dispensing with splints in this fracture, and merely enveloping the wrist with a snug strip of strong adhesive plaster. Such an appliance may be sufficient in simple cases, but where extensive laceration of ligaments has taken place it seems safer to rely upon a more rigid support.

After the first week passive, and later active, movement of the wrist should be practised. In four to six weeks the splints may be dispensed with. Before and for some time after removal of the splints, friction and massage should be employed to correct rigidity of the joint. Under twenty years of age we have to deal with separation of the epiphysis, and not with an ordinary fracture. The forearm is put up in a sling midway between pronation and supination. The hand, however, is not supported in the sling in order that the tendency to displacement towards the radial side may be overcome by its own weight.

OPIUM IN HEART DISEASE.

By Alexander McPhedran, M.B.,
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With few exceptions the symptoms of heart disease arise from deficient power in the heart to meet the demands made upon it. This is true whether the excess of work thrown upon the heart be due to disturbance of the circulation by disease of the valves, or to degeneration of the wall of the heart, reducing its power below the requirements of the circulation. Our conceptions of heart disease are so intimately associated with disease of the valves that too often the two conditions are looked upon as identical, or, rather, that the changes in the heart wall are secondary to the disease of the valves.

The valves are but mechanical structures, and disease of them, apart from infective processes, gives rise to symptoms only as it deranges their mechanical action, and thus leads to disturbance of the functions of the heart, and through this to degeneration of the cardiac walls. Cases resulting from lesions of the valves form only a small proportion of all the cases of heart-failure.

Pathological changes in the heart occur much more frequently as part of disease of the general vascular system. It is in such cases that the most mature judgment is required in estimating the amount of injury to the cardiac muscle and its powers of recuperation, as well as the best means to be adopted to restore its powers so that they may be adequate to the demands made upon them.

In the treatment of cardiac failure our aim should be twofold, viz., first to reduce the work of the heart as much as possible, and, secondly, to stimulate and strengthen its walls so as to enable them to perform their work adequately.

Of the means at our disposal to reduce the demand made on the heart, the most important is, of course, rest. By rest we seek to relieve the heart of all work except that necessary purely for the maintenance of life. Many patients are restored again and again

from incompetency of the heart by rest in bed alone. Each recurring attack of failure is more easily induced than its predecessor, and the restoration of competence is effected with more difficulty, until rest alone is unequal to the task of restoring effective power to the heart.

As the effect of physical labor is to greatly increase the strain on the heart, it follows that the benefit of rest in restoring the fail ing heart will be much greater in the man engaged in physical labor than the man leading an easy life. In the laborer the heart obtains relief to a much greater degree by rest than does the heart of his more fortunate neighbor. In the former, rest may mean the removal of three-fourths or more of the heart's ordinary labor, while in the latter, not more than one-fourth or even less of its work is relieved. Another fact of great importance in the difference between the two is that in the laboring man the diseased heart fails early, while in the man of easy life it is not until the heart is far advanced in degeneration that he shows the signs of failure. The former will therefore possess much greater recuperative power than the latter.

When the cardiac changes have advanced so far that rest alone is insufficient to restore competency to the heart's action, the end, for a time, may be attained by the use of cardiac tonics and stimulants to aid the rest in restoring the equilibrium.

In addition to rest the labor of the heart is also greatly relieved by full elimination of the waste products in the blood through the kidneys and bowels. It is probable that this in a great measure affords the explanation of the great benefit often reported from the use of calomel in cardiac disease with dropsy. Any purgative that causes free liquid evacuations will do good.

If the circulation is in fair condition, the drinking of water on an empty stomach is probably the best diuretic, and therefore the most efficient stimulant to elimination by the kidneys. Any remedy that increases the force of the circulation will, of course, proportionately increase the excretion by the kidneys.

In advanced cardiac disease, especially after repeated failures, complete rest of body and mind, aided by free administration of cardiac stimulants and tonics and the judicious use of purgatives, often fails to give relief. The signs of cardiac incompetency increase; there is increasing dropsy and dyspnœa with insomnia. The rest of the body is not sufficient to bring the needed rest to the heart; it remains irritable; its action becomes increasingly irregular. The patient grows weaker, the paroxysmal dyspnœa increases.

Almost as soon as he falls asleep a severe attack of dyspnœa causes him to awake and sit up in bed. The distress from the dyspnœa is great, but that from want of sleep is greater These are cases in reality of *angina sine dolore*. Such a condition is rarely benefited by the freest possible use of digitalis or other cardiac tonics and general stimulants. If the dyspnœa is not due in part to effusion into the pleura and œdema of the lungs, a dyspnœa that is persistent and not paroxysmal as cardiac dyspnœa is, there is no remedy so effective in such a condition as morphine. The comfort afforded by a hypodermic injection is almost incredible. Given by the stomach it often fails even in much larger doses, because absorption is so slow on account of the venous stasis in the mucous membranes of the stomach as well as of other parts, caused by the impeded circulation. In most of the writings on the treatment of cardiac failure too little is made of the great benefit to be obtained by the use of morphine in such conditions. Many of them make no reference to morphine at all in connection with heart disease; a few place its efficiency in severe heart disease next to digitalis. I am inclined to look upon it as even more important than digitalis in these cases, in fact, as indispensable. The following cases show well its great usefulness.

Case 1. O'Neill, aged 70, rather a small man of spare habit. Had been a business man, and not been subject to much hardship or dissipation. He was admitted to the Toronto General Hospital suffering from the effects of acute heart failure. This was his third attack. He presented all the usual symptoms, viz., attacks of extreme paroxysmal dyspnœa and well-marked Cheyne-Stokes respiration; insomnia, starting up with an attack of dyspnœa as soon as he fell asleep; extremely irregular, tumultuous action of the heart, many of the contractions giving no pulse at the wrist; considerable dropsy of abdomen and legs; a large liver; loss of appetite, with considerable flatulence. He was unable to lie down; he was propped up in bed with a back-rest. The bowels were acted on freely with calomel, followed by salines. Digitalis, with general stimulants, were given freely. His diet was light and nutritious. Ten days later, there being no improvement, morphine, one-fourth grain, was given subcutaneously at bedtime. It was followed by a good night's rest, with corresponding improvement in the general symptoms next day. The morphine was repeated every night for a week, by which time the heart's action was regular, the area of pericardial impact and dullness materially reduced, the dropsy had almost wholly disappeared, the appetite had become much bet-

ter, and his general condition correspondingly improved. Two weeks later he left the hospital in good condition. Of course, the heart was still large, and it was only a matter of time, he was told, until the symptoms would return. He was enjoined to take active exercise within the limits of perfectly easy breathing, and to avoid over-strain, exposure, over-eating, and dissipation of all kinds. Six months later he returned with a relapse, but it was much less severe than the former attack, and he recovered from it after a short stay. He has not been heard from since.

Case 2. A Russian Jew boy, aged twelve, entered the Victoria Hospital for Sick Children, March 31, 1896. He had always been a weakly child. Had a mild attack of rheumatism when nine years old. Two weeks before entrance into the hospital he had a sudden attack of hemiplegia of the right side. He had recovered the use of the leg fairly well on admission, but the arm was helpless. He complained on entrance of severe pain in region of spleen, for which he received morphine, one-tenth grain, three times. His heart was enormously enlarged and showed all the signs of acute failure of compensation. There appeared to be disease of both mitral and aortic valves. The ends of the fingers were clubbed to an extreme degree. A week after admission his temperature, which had reached as high as 104° F., became normal, but the circulation did not improve. The dyspnœa was very distressing, so that his nights were very restless. For this, morphine, one-eighth grain was given subcutaneously every night with the most satisfactory results, but it had to be continued for a month. His condition improved and he was able to sit up. His temperature would frequently rise a few degrees without any apparent local cause. He did not regain strength enough to go about, but his circulation improved so much that he rested with comfort, and his appetite was good. He became suddenly prostrate on June 1, and died in a few hours.

Case 3. Wm. E., aged sixty-six. A civil servant suffering from great dilatation, with extreme dyspnœa, insomnia, and dropsy. He had been treated before I saw him with strophanthus, digitalis, caffeine, etc., but without improvement. Morphine, one-fourth grain, at bedtime gave a good night's rest; it relieved breathing and steadied the heart. Magnesium sulphate was given every morning to produce a free liquid evacuation. After three days the morphine was stopped and codeine and caffeine, each two grains, and calomel, one grain, given instead, with chloralamide, twenty grains, at bedtime. Digitalis was also given. This gave good rest

at night and made him sleep almost all day, so that the chloralamide was omitted and codeine reduced to one grain. In a few days he became nauseated, and both digitalis and codeine were stopped. His progress was satisfactory, and a general tonic was ordered. To maintain a stimulus to the circulation dessiccated suprarenal capsule, two grains, three times a day, was given. His restoration was very satisfactory under the circumstances. He resumed work in October, and remained well until November, when failure of compensation again occurred and increased gradually. It required morphine, one-half grain, to secure rest and sleep. Not improving well, saline baths were resorted to, but with only moderate benefit. He improved slowly and was able to go out somewhat afterwards. He died suddenly a few months later.

These cases illustrate the benefit to be obtained from the use of morphine when the failure of the heart appears to be largely due to exhaustion of the nerve centres, as shown by the irritable action of the heart and the paroxysmal respiratory distress. The morphine quiets the irritable heart and enables the patient to obtain sleep during which excretion is increased and the circulation and nutrition improved. In proportion as the dyspnœa and distress are due to serious effusion into the pleural cavities, the pericardium, the lungs, etc., morphine becomes less efficient in giving relief. In these cases the symptoms are due largely, if not wholly, to mechanical causes resulting from the presence of the serous exudate, and can only be relieved by removing these causes. In these the symptoms are constant in so far as they depend on the exudate.

A CASE SHOWING IN A PECULIARLY MARKED MANNER ONE OF THE EFFECTS OF EYE-STRAIN.*

By G. Herbert Burnham, M.D., F.R.C.S. Edinburgh, M.R.C.S. England.

Associate Professor of Ophthalmology and Otology, Toronto University, and Oculist and Aurist to the Toronto General Hospital and Mercer Eye and Ear Infirmary.

George R. S——, aged 58 years, was sent to me September, 1894, by Dr. Millward, Grimsby. The patient gave me the following history:

Twenty-eight years ago there began a severe pain in his left eye, temple and side and back of head, which lasted more than one year. At times the pain was so agonizing that frequently during this period hypodermic injections had to be given.

At the end of this time the pain gradually lessened in violence and a few months later was gone. The sight of the eye then became very poor, that is perception of large objects merely. His head and eyes, he says, gave him no trouble till four weeks prior to consulting me, when a pain began in his right eye, temple and side and back of head. It quickly assumed the same degree of severity; in fact it exactly resembled the pain which he had in his left eye twenty-eight years before. During these four weeks he was frequently given hypodermic injections of morphia on account of the agonizing pain. On examination I found the left eye with a normal fundus and a good deal of hyperopic astigmatism; the right was also normal, but showed a small amount of hyperopic astigmatism. I ordered glasses as follows: Distance, R. + 0.50 sp. $\frown$ + 0.50 cyl. ax. 180, L. + 3. cyl. ax. 180°. Reading, + 2.50 sp. was added to each eye. I ordered him cemented bifocals to be constantly worn and gave him no medicine.

In two months afterwards he reported to me, saying that since the use of the glasses the pain had disappeared and he had felt no return whatever. This was, of course, a very gratifying result. He felt that the change in his left eye was almost miraculous, because

* Read before the Toronto Medical Society, February 18th, 1897.

useful vision had been restored to an eye that he believed to have been blind for twenty-eight years. The conclusion seems naturally to be that the agonizing pain in the left eye twenty-eight years ago was due to the great efforts the eye had made to overcome the error of refraction and secure binocular vision. With the cessation of these efforts, that is with the almost total suppression of the image of the left eye, the pain vanished. No return was *felt* till the error of refraction of the right eye, combined with the presbyopia, caused undue efforts to be made. That as fierce nerve-centre explosions had been caused years ago from overstrain, these centres were much more easily aroused, than they otherwise would have been, to a display of excessive activity. That the trouble with the right eye did not occur earlier was because the glasses he was wearing, when he consulted me, had sufficiently aided the right eye to cause a delay but not to prevent a nerve-storm. The correction of the left gave excellent vision $\frac{20}{30}+$. One question that might be asked is, why did not the pain begin before he was thirty years of age, as the error of refraction was always present? To that I cannot give any more accurate answer than that it is sometimes impossible to say when a person having an error of refraction will begin to suffer from the consequences of eye-strain. Often the effect of the eye-strain shows itself very early and again not till very much later. The reason of this is very difficult to give, but often the surroundings, occupation and certain peculiarities of the nervous system seem to be potent factors.

This case also shows the great necessity in all affections in any way connected with the head of remembering the peculiar and apparently out-of-the way effects caused by eye-strain. In all central disturbances showing the alarming symptoms presented by the case under consideration, a most careful and exhaustive examination should be made. It is not at all derogatory to the general practitioner to say that it is impossible for such an examination to be made by him. Neurologists now seem to take a much more favorable view of many nervous affections than they once did; for they have realized that the so-called incurable structural lesions are not as great a factor in every case as they once thought. In May, 1896, I received a letter from the patient herein mentioned, who said that ever since he began to wear the glasses I ordered him in September, 1894, the pain had completely disappeared.

I have narrated this case to impress upon the members of the medical profession the peculiar nature and very great severity of some of the nerve-centre explosions due to over-strain of the eye.

Selected Articles.

THE PRESERVATION OF THE HYMEN.

By Howard A. Kelly, M.D.
Baltimore.

IN Celsus' "De Medicina," written about the time of Christ, in the chapter on calculi, after declaring that small calculi may escape spontaneously through the shorter and more relaxed urethra, he says that in most cases it will be necessary to apply the same methods of hooking the calculus down and holding it against the neck of the bladder while incising, as in men, but he adds the caution that in the virgin the finger must be introduced per anum, as in the male, while in married women it may be introduced into the vagina.

Severin Pineau, in his work written at the end of the sixteenth century on the signs of virginity, quotes the ancients as his authority for the dictum, "it is criminal to rupture the hymen" ("magnum est crimen perrumpere virginis hymen").

And such has been the attitude of the profession through all the centuries of the past; honorable men have ever carefully guarded as sacred the rights and the interests of the young women who have trusted their persons to their professional care, and the barrier which Nature has erected at the vaginal introitus as the sole *prima facie* evidence of virginity has been preserved intact.

I wish now to urge, in the first place, that it has remained for our day and generation, at a time when the study of the diseases of women has become a fashion, for practitioners of medicine to ruthlessly disregard all moral considerations and make digital examinations of young women with pelvic pains at the menstrual period, or those presenting any abnormality in the menstrual flow or complaining of a leucorrhœa.

I know not how else to characterize this *cacoethes examinandi*, this reckless habit of investigating the sexual organs of young women, than as a species of rape.

I know, for example, of a large institution in our city entrusted with the education of young women from all parts of the country. In numerous instances young girls with purely functional dysmenorrhœa are taken to a physician, who examines them, inserts specula, and institutes treatments where, as I have had occasion to verify, there is actually no discoverable local disorder whatever.

Other young women are constantly coming to me from a distance with the statement that they have "ovarian disease" or "tubal disease" or "anteflexion of the womb," who are perfectly sound and who ought never to have been examined at all; and I have thus to record in my case-book in numerous instances "no pelvic disease" or "metrophobia"—a word I have coined to designate those who are fully assured they have some grave "womb trouble," but are, notwithstanding, perfectly sound.

Aside from all the hospital cases I have seen, I find in my private case-book the records of twenty-eight cases with no pelvic disease out of a total of 550 in all, about 5 per cent.

While male physicians are great offenders in this respect, many of the women who practice medicine are far worse; indeed, they often seem to possess no conscience whatever in dealing with these sacred interests of their own sex.

A young woman with a natural sense of shame, but utterly guileless of any knowledge of anatomy, feels that it is easier for her to speak of her pelvic discomforts to one of her own sex; but the woman doctor (with many noble and conspicuous exceptions, I am happy to say) then feels, on her part, that it is necessary, in order to make a complete investigation of every case, to inspect the genitals and to insert her finger into the vagina; she generally ends by putting in a speculum, too, and tampons, and so begins a never-ending course of so-called "treatments," during which the natural ups and downs of health encourage the trusting victim to think at first that the "treatments" are benefiting her, and then, when the pains recur, that there surely is something at fault, and so it continues for years. Sooner or later, in many cases, an infection is introduced, and from having no disease at all she is inoculated with a salpingitis, and she is fortunate, finally, if she escapes a radical operation removing her uterine tubes and her ovaries. The records of this country within the past twenty years could show, I verily believe, thousands of such victims, at first unnecessarily insulted, and then robbed of their distinctive organs of sex for imaginary ailments or diseases acquired.

Such is the character of this evil; of its extent no one can do

more than roughly estimate. My own experience leads me to conclude that these vicious practices are both general throughout our country, and that they affect our young womanhood to the extent of inflicting an unnecessary injury upon many thousands yearly.

In case an examination is actually necessary, it must be made by one who is thoroughly competent to decide at once whether or not there is any disease present, and who will be able to proceed at once to do all that may be required to relieve it. By dilating a cervix, or rupturing a large Graafian-follicle cyst, or breaking up adhesions, oftentimes all can be done at once which it is possible to do at all, and the patient will be spared the distress of useless and endless so-called "treatments," which consist in the application of drugs to the vaginal walls or to the cervix, anatomical structures distant from and quite distinct from the supposedly affected organs.

I would urge that there are satisfactory methods of examining young women which need shock no sensibilities and which inflict no injury upon any organ.

In the first place, if the patient has not been examined and treated before and an examination is necessary, it is my invariable practice to propose to do this *under complete anæsthesia*, in this way securing a perfect relaxation, with every facility for making the minutest investigation which it is possible to make, short of actual inspection through an abdominal incision. The anæsthetic obviates the inevitable resistance of the abdominal walls, and the examination leaves behind it no disagreeable memories.

In the second place, when the patient is anæsthetized *the examination must be conducted through the rectum.* The cervix can be easily palpated through the recto-vaginal walls; and as for the body of the uterus, the ovaries, and the tubes, they cannot be clearly palpated in any other way. The rectal examination is therefore not only to be recommended because it spares the hymen, but because *it is actually indispensable to a thorough investigation.*

I have shown on another occasion that the most minute examination may be made by the rectum if the pelvic organs are first skeletonized by putting the patient in the knee-breast position to let in the air and so getting rid of the intestines. After doing this the examination is conducted in the dorsal position. If the finger is not more than 6.5 centimetres in circumference, it may often be inserted into the vagina, slowly and with extreme care, without rupturing the hymen; this is, however, not a good rule, for the tactile sense of many men seems to be so blunt that there is no appreciation of resistance when delicate structures are being investigated, and harm is done unawares.

In the third place, if it is necessary to dilate and to curette the uterus, this may be done by introducing a finger into the rectum and locating the cervix, and then introducing a pair of tenaculum forceps into the vagina and carefully opening them, and catching the cervix and drawing it down to the outlet, where it may then be dilated and curetted, in many cases, without injuring the hymen.—*Abstract, Amer. Jour. of Obstetrics.*

THE DISINFECTION OF THE EXCRETA.

By Chas. A. Hill, B.A., M.B., B.C.Cantab.,
and
John Hill Abram, M.D., London, M.R.C.P.,
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THE methods used for ascertaining the value of any disinfectant are mainly two—namely, the addition of definite quantities of the substance to an active broth culture, with subsequent inoculation upon various media after the lapse of varying intervals, and the action of solutions of known strength upon test organisms inoculated upon threads.

We have limited our enquiry to the disinfection of the fæces, as naturally they are the most resistant. In our earlier experiments the disinfectant solution was added in excess to the solid fæcal mass, but we speedily found that in not a single instance did we get any sterilization of the central portions. Therefore we would insist upon the necessity for thoroughly mixing up the fæcal matter with the disinfectant selected.

We have chosen half an hour as the time during which the mixture must be allowed to stand, as being a convenient one in practice, though we admit that it is a severe test, and no doubt explains some of our results.

The accompanying table gives our results at a glance:

Disinfectant.	Strength.	Action on Fæces.	
		When Mixed.	When Unmixed.
Perchloride of mercury...	1 in 1,000	Spore-bearing forms	Copious growth.
Formol.....	1 in 20	Sterile	Copious.
Carbolic acid.....	1 in 20	Sterile	Copious.
Iodic hydrarg.....	1 in 4,000	Spore-bearing forms	Copious.
Chloros.....	Undiluted	Limited	Limited.
Chinosol.....	1 in 600	Sterile	Copious.
Izal.....	1 in 200	Spore-bearing forms	—
Creolin.....	1 in 10	Sterile	—
Carbolic acid (crude).....	Undiluted	Sterile	—
Zinc chloride	1 in 10	Copious growth	—
Copper sulphate.....	1 in 20	Copious	—
Boiling water	—	Copious	—
Sodium chloride.....	1 in 10	Copious	—
Chloride of lime, 15% Cl..	1 in 10	Copious	—
" " 35% Cl..	1 in 10	Considerable	—

It will be seen from the table that we have found corrosive sublimate and crude carbolic good disinfectants. The mineral acids we have not tested, as there are many and obvious objections to their use. Chlorinated lime we find with our time limit of half an hour to be useless. It may be said the preparations were old, but we submit that such an objection necessarily puts the substance out of court. Any of the six disinfectants on our select list may be regarded as absolutely certain in their results when thoroughly mixed with the stool and allowed to stand for half an hour. There are, however, objections to the use of some of them.

Corrosive sublimate is a scheduled poison, acts upon the metal work of the drainage system, and moreover gives a red coloration with stercobilin. This latter point is of importance, inasmuch as it may mask the presence of blood in a typhoid stool; again, albumen is coagulated by mercuric chloride, and thereby protects organisms enclosed in the centre of the coagulum. Crude carbolic acid is cheap and efficient, but does not mix over-well with the fæces; it stains linen, and is poisonous. Formol and creolin are good, but are rather costly. The remaining substance, chinosol, is, in our opinion, the best. It is reliable, an excellent deodorant, and mixes well with the fæces. It is dearer than crude carbolic, but its cost is more than counterbalanced by its portability. It is put on the market in tablet form. The tablets are readily soluble, and may be obtained in such strength that one of them in a pint of water makes a solution of effective strength.

We may sum up our paper with the following conclusions:

1. It is absolutely necessary to mix the fæces thoroughly with the disinfectant.

2. The mixture should stand at least half an hour.

3. Carbolic acid, crude carbolic acid, formol, creolin, chinosol, and corrosive sublimate in the strengths given in the short list are all effective, but chinosol seems the most convenient.—*Abstract British Medical Journal, April 16th, 1898.*

THE FARADIC CURRENT IN THE TREATMENT OF EPILEPSY.

By Prof. Sgobbo.

AMONG the many remedies employed in epilepsy electricity is one which has been followed by results almost always uncertain and usually without benefit. Vigouroux is of the opinion that those who say they have obtained improvement by the electrical treatment of epilepsy have cured cases of hysteria, and Bardet states that all remedies have been used in this terrible disease, and, unfortunately, it cannot be said that electricity has rendered any confirmed benefits.

As early as 1753 Lindhult tried electricity in epilepsy, and in 1785 Ledru founded, at Paris, an institution for the electrical treatment of this disease and there obtained good results. Harris, in 1834, used galvanic electricity in eight epileptics, of whom five were completely cured in less than a month, according to the author. In 1842 Person treated an epileptic girl of twelve years by galvanic acupuncture, applying a needle to the epigastrium and another over the first cervical vertebra. Bougard, in 1859, treated by electricity sixteen cases, of which four were cured. Althaus preferred the galvanic current, and had some cures. He applied the poles over the mastoid processes, over the sympathetic nerve, and in the course of the nerves where the aura was developed. Brunelli had a very good result in a boy of eleven years, from faradization, placing at the beginning of the setting one electrode at the nape of the neck, and the other alternately over the epigastrium and in one of the hands; and at the end of the sitting, for a few minutes, both metallic electrodes in the hands. Neumann, arguing from the view that epilepsy is an affection of the cortical substance of the brain, advises (1) firmly, from one half to one minute, with a current at first weak, the metal anode in the upper region of the forehead and temple on one side and the cathode on the opposite side of the nape of the neck, and similarly with the other side; (2) galvanization of the sympathetic in the neck; (3) the electro-static bath in the form

of shower bath, avoiding the action of the sparks on the vertex. Erb believes that every effort in the treatment by electricity must be directed chiefly towards removing the epileptic modification from the brain. Stein and Benedict have used the electro-static shower bath with benefit.

Here, I think, we can safely assert that the electrical treatment can give good results in epilepsy. The cases of cure reported by the first authors lead me to admit, with Vigouroux, that hysteria was treated. Erb expresses himself thus as to the results of electricity:

"I, myself, have lately tried electricity in some cases, using at the same time other methods of treatment, and have had such good results that I feel encouraged to make further trials; two serious cases, especially, by means of the combination of electricity and bromide of potassium, and later, cold water, improved so surprisingly that I am led to see in electricity an excellent aid to the bromide treatment, which is doubtless the sovereign remedy."

In the Hospital for Nervous Diseases and for Electrotherapy, under my direction, in 1894, I began a series of experiments in the treatment of epilepsy. Out of 1,000 patients only thirty-seven suffered from epilepsy and epileptic convulsions. Of these thirty-seven only twenty-two were treated electrically; the other fifteen receiving bromide of potassium for the sake of comparison.

The different methods of electrical treatment used in epilepsy are: general faradization, galvanization of the head, of the sympathetic in the neck, the electro-static shower bath.

My efforts were directed towards proving whether faradization of the anterior and lateral regions of the neck were of benefit in the epileptic attack.

In 1894-95 I published, in the Annual Report of the Hospital, the first results, which were very encouraging—results which I have confirmed in my work, "Medical Electricity," (Naples, 1897).

This is the method adopted:

A large electrode, well moistened and curved, is applied at the level of the thyroid cartilage, the other electrode is held by the patient in his hand or on the sternum. I always use on alternate days the faradic current of medium intensity, for fifteen minutes.

[Then follows an account of fifteen cases, the other seven not presenting themselves regularly at the dispensary. I shall quote only the first of these cases.]

(1) N.P., from Naples, thirteen years old. Nothing special in family history. At six months was seized with convulsions, which

were repeated after two months. At the age of two years, after a fall, the convulsions returned and occurred frequently. The convulsive attack had all the characteristics of epilepsy. He took bromide of potassium for thirty-three days, without benefit. Then he received electrical treatment for two months and the attacks have not been repeated. . . . . .

From observation of all these cases, we infer that the electrical treatment generally gives relief, since almost without exception, after a few sittings, it either diminishes the frequency of the convulsive attacks or makes them disappear entirely or for a long period. The other fifteen patients, not subjected to electricity, took bromide of potassium or sodium in pretty large doses and generally had no perceptible improvement. But how does the electro-faradic current, applied in the anterior region of the neck, act on epileptics? At present we cannot answer this question. We cannot say whether the lessening of the attacks is due to the action of the current on the nerves of the neck and thence on the cerebral circulation; or whether the faradic current in the neck, in the same way as the galvanic current, acts on the nerves of the neck, so as to modify the cerebral circulation; or whether the current, besides its action on the nerves of the neck, acts on other organs, perhaps not excluding the thyroid.

Suffice it to say for the present that faradization of the anterior region of the neck in epileptics diminishes, or causes to disappear, the convulsive attacks.—*Translated from "Giornale Internazionale delle Scienze Mediche," for* THE CANADIAN PRACTITIONER, *by Dr. W. Harley Smith.*

Progress of Medicine.

ORTHOPÆDIC SURGERY.

IN CHARGE OF

CLARENCE L. STARR, M.B. Tor., M.D. Bel. Hosp. Coll.,

Surgeon to Industrial Refuge.

Assistant Demonstrator of Anatomy, Toronto University.

Fracture of the Neck of the Femur in Children.

This is a condition which merits our attention on account of the fact that it is so often overlooked, and it is overlooked mainly because we fail to cultivate our powers of observation sufficiently, and secondly, because we so often neglect to make a careful examination of the patient stripped of all clothing.

Dr. Royal Whitman, of New York, who has given considerable attention to this subject, states as a result of his observations that since 1890 he has seen no less than thirteen cases of this injury in children between the ages of two and a quarter and eight years.

The fracture, being incomplete or of the green-stick variety, often escapes observation, as the child is able to walk immediately after the injury in the majority of cases. In these neglected cases the head becomes depressed or the trochanter elevated above Nelaton's line, and the symptoms resemble somewhat those of hip-joint disease, although the limitation of motion is only in the direction of abduction, extension being scarcely affected. Careful examination of the stripped patient with careful measurement will generally establish the diagnosis.

Dr. Whitman endeavors to correct the bending of the neck of the femur by a cuneiform osteotomy, although a simple osteotomy may sometimes suffice.

Tuberculosis or Sarcoma of Hip-Joint.

At a recent meeting of the San Francisco County Medical Society Dr. Harry Sherman read a very interesting paper which shows

the difficulty often experienced in making a diagnosis between tuberculosis and sarcoma of the hip-joint. The paper reported eight cases of amputation at the hip-joint. Four of the cases were tubercular and four sarcomatous. The differential diagnosis in two of the cases of sarcoma was only made at the time of operation, and the points of similarity of the two conditions were very clearly brought out.

Two of the four cases of tuberculosis recovered and are at present in excellent condition. One case died of shock within a few hours of operation, and one died of pulmonary tuberculosis three months after operation.

Of the four cases of sarcoma one is alive at present, seven years after operation.

In two of the fatal cases the termination was strangely alike. The first case showed no sign of recurrence for fourteen months; then suddenly a very severe and persistent pain appeared in the right side of the chest. The chest was aspirated on two occasions and a large amount of fluid blood drawn off. In a few weeks a similar condition commenced in left side, producing death in short time apparently from suffocation.

The autopsy revealed right lung apparently completely disappeared and only a small tumor taking its place in which no lung tissue was found. The space was entirely filled with blood.

Sarcomatous infiltration was found on anterior surface of left lung and the hæmorrhagic process begun.

The second fatal case presented almost exactly the same symptoms—pain in the chest, pressure and aspiration of fluid blood, followed by death shortly after onset of chest symptoms.

No autopsy was performed, but in all probability the same pathological condition was present as in preceding case—*Phil. Med. Jour.*

LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF

PRICE-BROWN, M.D.,

Laryngologist to Western Hospital; Laryngologist to Protestant Orphans' Home.

Removal of Foreign Body from the Nose after Twenty-three Years.

S. W. Carruthers (*Brit. Med. Jour.*, Feb. 12, 1898) gives the history of a peculiar case. A little girl, seven years old, was pushed down, and got something in one side of her nose, which twenty-three years afterwards proved to be a stone. It always produced more or less irritation, and at the ages of eleven, thirteen, and twenty-seven she had polypi removed by different surgeons from the same nasal fossa, who, however, did not appear to have discovered the stone. When the woman was thirty Carruthers was consulted. He found a hard foreign body, lodged about an inch from the nares, above the inferior turbinated. He extracted it with forceps. He accounted for the comparative freedom of breathing through the affected nostril which the patient had always enjoyed to the position of the stone. The dimensions of the stone are not given, but it was large and nodular, and free from the calcareous deposits of which rhinoliths are composed.

Resection of Facial and Nasal Walls of the Antrum with Invagination of Nasal Mucous Membrane into the Cavity for the Cure of Obstinate Crupvnea.

Bonnereghaus (Archiv. fur Laryng. *und Rhinol.* Band VI., Heft 2.) A large number of patients suffering from antral disease remain uncured for years, in spite of treatment. For this condition the author describes a method of surgical treatment which he has used successfully in a number of cases.

First, any carious teeth of the superior maxillary on that side are removed and their alveoli scraped. An incision is then made down to the bone from opposite the second incision to the wisdom

tooth. The tissues are next dissected upwards to near the infra-orbital foramen. Then sufficient of the anterior wall is removed to allow of a thorough examination of the antrum. The necrosed bone on the nasal side is carefully dissected out, taking care to keep the nasal mucous membrane without perforation. Within the antrum itself the diseased mucous membrane is scraped from the underlying bone. Care is taken not to interfere with the bony walls of the lachrymal canal. The separated nasal mucous membrane which now forms the sole partition between the nose and antrum is pushed from the nose into the cavity and kept in position by strips of iodoform gauze. The mouth wound is packed also with iodoform gauze. In a few days the nasal mucous membrane will have adhered to the walls of the antrum. After-treatment consists in cleansing by blowing and washing out night and morning; the oval aperture remaining open for inspection and cleansing.

(Query: Would not the enlarged nasal cavity have a tendency to produce atrophitic rhinitis?)

Supra-Tonsillar Fossa and its Affections.

Donald R. Paterson (*Jour. Laryng.* etc., April, 1898), in a long article, draws attention to the existence at the upper and anterior side of the faucial tonsil of a fossa, hitherto looked upon as a mere tonsillar crypt, but in reality not in any sense of that nature. Having arrived at this conclusion from personal observation, he examined extensively into throat literature, but could get no light upon the subject, except that he found that His, in the year 1885, described the cavity as an "anatomical space." Later on, after more extensive investigation, His gave it the further title of "supra-tonsillar fossa."

A web of membrane, particularly in young subjects, is frequently found to be attached to the free border of the anterior pillar, extending downwards and backwards over the tonsil, called the plica triangularis, and it is between this plica and the upper portion of the tonsil that the supra-tonsillar fossa is found.

One of the chief features of the fossa is the tendency to the accumulations of tonsillar secretions within the cavity, induced by the presence of the plica, a kind of pouch having been formed. The object of treatment is free drainage, either by punching out the upper portion of the tonsil, or removal of a portion of the plica. Papilloma may form upon the plica; malignant disease has also been known to commence in the fossa, while foreign bodies have in a few instances been found lodged within it.

Papilloma of the Tonsil.

In the February number of the *Journal of Laryngology* a number of cases of papilloma of the tonsil were reported by different members of the London Laryngological Society. Although these neoplasms are common on the palate and pillars, records of their occurrence upon the tonsils have been exceedingly rare. At this meeting Hill, Wingrave, Wagelt, Butlin, Horne and Yearsley all reported cases. In all of them the attachment was pedunculated, and limited to a particular spot upon one tonsil. After removal no case of return has been reported.

Mention might be made here of a case reported by T. H. Machell, of Toronto, to the Toronto Medical Society several years ago, and published in the *New York Medical Journal*, Jan., 1895. In this case what were supposed to be papilloma studded the tonsils completely. They were all pedunculated, each growth having a distinct pedicle. The patient died of scarlet fever. This appears to be the only case on record of such widespread and diffuse papillomatous growths of the tonsil.

Two Cases of Laryngeal Spasm Fatal, in the First Attack, Occurring in the Same Family.

C. H. Hunter (*Brit. Med. Jour.*, April 2, 1898) gives a brief outline of these remarkable cases, both being perfectly well up to a few minutes before death, and occurring within two days of each other. The first was a boy nineteen months old, one of twins, the other having died a month after its birth. Just before his death his mother took him up to wash him. In a fit of passion he threw his head back and became livid and rigid. He was at once put in a hot bath; but this was of no avail. He died without uttering a sound, and before the doctor arrived. Two days later he was hastily summoned to the boy's sister, aged seven months. The doctor arrived within two or three minutes but found the baby dead. The mother said in this case that the child was lying perfectly well and quiet in her arms. Suddenly without any screaming, the baby became rigid and blue in the face, and died without uttering a sound, just as her brother did.

In both cases there were well marked carpo-pedal contractions, but no general convulsions. In neither case had there been crowing respiration. In the post-mortem examinations all the organs were found healthy. There were no laryngeal obstructions, but there were some indications of rickets. Frederick Taylor says that

rickets is found in seventy-five per cent. of the cases of laryngismus stridulus. This might be the predisposing cause in these cases.

Recurrent Membranous Pharyngitis.

Middlemas Hunt (*Jour. Laryng.*, Feb., 1898) reports a case of this disease in a middle-aged lady which had lasted for 19 years. The attack would begin with acute sore throat, followed by formation of membrane over the left tonsil and wall of the pharynx, and also on the left side of posterior surface of epiglottis. This would last for a week or two and then gradually disappear. After a similar interval it would be repeated. This went on year after year for the whole of that time, with the exception of a period of four months, when she was confined to bed from injury to the foot. The membrane on the epiglottis was not continuous with that of the pharynx.

Microscopical examination proved the absence of Klebs-Loeffler bacillus, but the presence of streptococci and staphylococci. Middlemas Hunt was of the opinion that the disease had each time been artificially produced. He ascertained that the patient had a prescription for Liquor Epispasticus repeated at long intervals. He had given this to her some months before the trouble originally began.

In reference to this matter, French soldiers have been known to escape duty by producing artificial membranous sore throats, resembling diphtheria, by rubbing in powdered cantharides with the finger.

Multiple Papillomata of the Larynx in Young Children Treated by Tracheotomy Only.

T. C. Railton (*Brit. Med. Jour.*, Feb., 1898) gives the history of two little girls, aged respectively three and four years; both had multiple laryngeal papillomata: tracheotomy in each case gave immediate relief to respiration. One required to wear the tube for forty-five months before the growths were all absorbed; the other for twenty-five months. In each case the child made a good recovery eventually without any return of the papilloma. At first silver tubes were worn, then soft rubber ones. The latter were renewed three times a week. In his remarks, the writer attributes the spontaneous atrophy of the growths to the removal of the irritation of respiration and coughing.

Impaction of Coin in Œsophagus: Ulceration into Aorta: Death.

T. H. Hawley (*Brit. Med. Jour.*, March, 1898) was summoned to attend a boy aged four years seven months, suffering from collapse, after vomiting a pint of blood. His condition varied for ten hours; then another violent attack of hæmatemesis was followed by immediate death.

The history showed that six months previously the boy had swallowed a halfpenny. From this time forward he complained of pain on the right side of the throat after swallowing food, which had always to be of a semi-fluid nature. There had been no loss of flesh, no bleeding, no vomiting, no regurgitation.

On post-mortem examination the halfpenny was found impacted in œsophagus about an inch below the level of the aortic arch. The edges in contact with the œsophagus had formed two deep ulcers. The one on left had eaten into the descending aorta, making an opening large enough to admit of a quill.

Œsophagotomy and Removal of Dental Plate with Upper Central Incisor Teeth.

A. A. Snyder (*New York Med. Jour.*, Sept. 1897) gives the history of the case. A woman, aged 22 years, had swallowed a broken dental plate. It lodged in the œsophagus. The voice became affected, and she complained of pain on the left side of the sterno-clavicular joint. Owing to irritability of the parts, even under cocaine, removal by the natural passage was impossible. On the third day, having localized the foreign body, a two-inch incision was made along inner edge of sterno-mastoid muscle. The jugular vein and common carotid were exposed, and the œsophagus being entered through the wound, the plate was extracted. The size was one and a half inches by one and a quarter. The patient made an excellent recovery. In this case the X rays were tried but failed to locate the foreign body.

Editorials.

THE ONTARIO MEDICAL ASSOCIATION.

THE eighteenth annual meeting of the Ontario Medical Association will be held in the Normal School buildings, St. James' square, Toronto, June 1 and 3. We are informed by the General Secretary, Dr. John N.E. Brown, that the two important committees in connection with the meeting have completed their arrangements. The committee on papers, under the chairmanship of Dr. A. McPhedran, have framed a provisional programme which gives good promise. An effort will be made to have a smaller number of papers read and longer discussions than we had last year. There was certainly a general feeling at the meeting in 1897 that the discussions were altogether too brief. We hope the committee will not go to the other extreme this year of allowing proceedings to drag and become tiresome. It is only fair to say in this connection that the work of the different committees on papers during the last few years has been admirable in all respects, and the efforts of the committee for this year are likely to prove equally satisfactory.

The programme of the Committee of Arrangements will be somewhat similar to that of last year. The visiting members will be entertained at luncheon in the building of the Royal Canadian Yacht Club; and, if the weather is fine, they will probably be taken for a short cruise on the lake. Dr. G. Stirling Ryerson, the chairman of the committee, will preside at the luncheon. Although this entertainment last year was very enjoyable there was a slight feeling of weariness before its close. There was too much speaking. Three or four bright crisp speeches after luncheon go very well, but it is quite unnecessary to toast the whole creation. We publish in another column a list of papers promised up to the time of writing.

THE TREATMENT OF INEBRIATES.

WE are glad to publish in this issue an interesting letter from Dr. A. M. Rosebrugh, of Toronto, on this important subject. It is generally recognized by the profession, and, to some extent at least, by the general public, that inebriety is, in itself, a disease rather than a crime, and requires most judicious and careful treatment. Under such circumstances it is not advisable to imprison habitual drunkards with ordinary criminals; and yet some restraint should be placed upon them, because unbridled freedom for such people means danger to themselves and the public.

Dr. Rosebrugh has taken great interest in the subject for many years, and his opinions are, therefore, worthy of very careful consideration. The recommendations which are given in his letter are all in the right line, although it may be difficult to carry them all out within a short time. Although the Ontario Legislature has done much in the way of establishing and supporting many worthy charities, such as hospitals, asylums, etc., it is not up to date with reference to the proper treatment of inebriates and epileptics.

We are glad to notice in Dr. Rosebrugh's letter a timely suggestion as to combined treatment of these two classes of unfortunates in a large farm-colony. The Ontario Medical Association has made representations to the Government in these matters in the direction indicated by the doctor. We believe that only questions of economy cause the Government to delay action, and a little more pressure may induce its members to believe that false economy will in the long run prove to be quite expensive. Without discussing such considerations, we have to say that there is a strong feeling existing in the minds of our profession that in the interests of humanity something should speedily be done in the way of properly caring for both inebriates and epileptics.

THE GENERAL MEDICAL COUNCIL OF GREAT BRITAIN.

THE Medical Council of Great Britain is the supreme administrative body of the profession in England, Scotland, and Ireland. After the death of the late president, Sir Richard Quain, considerable interest was taken in the election of his successor. There was a pretty general feeling that Sir William Turner was eminently fitted for the position on account of the great executive ability he had shown in connection with the work of the Executive

Committee, of which he had been a member since 1887, and that of the Business Committee since 1892, and also on account of his high standing and reputation, which was world-wide. The only objection which could be raised against him was that he resided in Edinburgh, while many thought the president should reside in London, in order that he might be in constant touch with the central office of the Council. Some hoped that he might be induced to remove to London.

But, as it happens, residence in Edinburgh is not considered a drawback, as the following remarks by Mr. Teale, when he was proposing Sir William for the presidency, show: "There was also an accidental advantage in finding a man like Sir William Turner, namely, that he was a member of the Scottish Branch. The Council was not an English Council, but a Council of Great Britain and Ireland, and it was a desirable thing that now and then the more Imperial character of the Council should be emphasized by going outside England for its president."

Dr. Bennett seconded the proposition, and Sir William was unanimously elected. His election will afford eminent satisfaction to his numerous friends in Canada. He took an active part in the proceedings of the meetings of the British Science Association in Toronto and that of the British Medical Association in Montreal last summer; and, after Lord Lister, none was more popular than he. While in Toronto, he was the guest of Dr. Grasett, and met many members of the profession in a social way. Those who heard him at the various scientific meetings were impressed by his great ability, while those who met him outside of *shop* and science were charmed by his genial and kindly courtesy.

(Since the writing of this article we found the following note in *The British Medical Journal*: "We are informed that it is not Sir William Turner's intention to resign the Chair of Anatomy in Edinburgh University, and that the rumor that he would take this step in consequence of his election to the presidency of the General Medical Council is unfounded.")

Meetings of Medical Societies.

TORONTO CLINICAL SOCIETY.

Regular meeting held April 13th. Dr. Albert A. Macdonald, president of the society, in the chair.

The minutes of the March meeting were read and adopted.

The following fellows were present: Dr. Nichol, of Baden; George Elliott, William Thistle, William Aikens, Charles Trow, Graham Chambers, Elliott Brown, Geoffrey Boyd, Herbert Hamilton, Frederick Fenton, William Oldright, J. Algernon Temple, Herbert A. Bruce, William Pepler, LeM. Grasett, Albert A. Macdonald, George A. Bingham.

Dr. Herbert A. Bruce read a paper on "The Surgical Treatment of Osseous Ankylosis of the Temporo-Maxillary Articulation."* Dr. Bruce presented the patient for examination.

Dr. Grasett said this was the first case of the sort he had ever seen. He thought the result was very satisfactory.

Dr. Peters said he had seen one of the operations, at which time there was very little movement. His recollection was that the coronoid was not ankylosed by bone to the skull. The first week after the second operation the patient could voluntarily open the mouth so that there was a distance of three-quarters of an inch between the lower and the upper jaw. Probably a larger portion of bone might have been removed, but if much more had been removed the chin would have been drawn too much to one side of the mid-line of the face. Rather than this he thought it preferable to sacrifice one-quarter of an inch in the distance the jaws could be separated. He considered the result a very good one.

Dr. William Oldright drew attention to the comparative smallness of the teeth in the lower jaw. He had seen one case similar to the one presented, in which an attempt was made at breaking down the ankylosis by means of gags.

Dr. Pepler and Dr. Boyd made some brief remarks on the case.

Dr. Bruce replied.

* Will be published in June issue.

Dr. J. A. Temple presented: (1) Two ovaries in a state of cystic degeneration, which he had removed from a woman with a fibroid of the uterus. (2) A pus-tube, non-adhesive, from a woman, the wife of a farmer and mother of several children, who gave no history of symptoms. (3) A cystic ovary from a woman who had suffered from retroflexion of the uterus and prolapse of the ovary. (4) A fibroid tumor of the uterus which was causing great pain.

Dr. Grasett referred to the second case and Dr. Fenton to the last.

Dr. Pepler discussed the diagnosis of pus-tubes.

Dr. Oldright reminded the society of a pair of pus-tubes he had removed intact, and presented at the society last year.

Dr. Macdonald reported a case of amputation of the cervix uteri for carcinoma. The patient was a delicate woman, aged forty-five, who had a number of children, and had miscarried several times. When he first saw her two weeks ago, the question was whether he should remove the whole uterus, in which the mortality by vaginal hysterectomy is about fifteen to twenty per cent. The mortality from amputating the cervix being only two per cent., and the results about as good as the more serious procedure, he decided to amputate the cervix. He thought it added two or three years to the patient's life.

The nominations for the ensuing year were made.

TORONTO PATHOLOGICAL SOCIETY.

THE regular meeting of this Society was held in the Biological Department of Toronto University, March 26th.

Dr. H. B. Anderson, president, in the chair.

Present—Drs. McPhedran, Reeve, Wishart, Silverthorne, Pepler, Primrose, Rudolf, H. H. Oldright, Wm. Oldright, Peters, Wilson, Bruce, Amyot, Goldie, Carveth, McKenzie, Anderson, Parsons. Visitor, Dr. Small.

Meeting called to order at 9 p.m. Minutes of last meeting taken as read and adopted.

Fresh Specimens.—Dr. Wm. Oldright showed a fæcal concretion removed from an appendix.

Mr. J. J. McKenzie read a paper on the pathological changes in the chromophilous granules in nerve cells. (To be published later).

Dr. H. H. Oldright's paper on "Anomalies of Dentition" followed.

ANOMALIES OF DENTITION.

By H. H. OLDRIGHT, M.D., Toronto.

Anomalies of dentition, other than cases of dentigenous cysts, which may be found in various parts of the body, notably in the ovaries, may be classed according to the time of development and with reference to their situation and size.

I. *Late Development.*—Flint (Wm. Henry) says that:—In the different diatheses, struma, syphilis and rachitis the deciduous teeth may not erupt till a late period, as in a case cited by Steiner, 1885, where the teeth were not cut till the fourth year.

We may even have, as Charles Sarazin reports, complete absence of both sets from want of development of the dental follicles or disease of the alveolar process.

There may be symmetrical absence of certain teeth, the incisors, canines and wisdom teeth.

The first set may be perfect, the permanent set imperfect.

Supernumerary teeth may be present from the development of an extra follicle, or the segmentation of a follicle.

II. *Early Development.*—It is said that Louis XIV. and Mirabeau were each born with a complete set cut. In these cases the roots are, as a rule, rudimentary, and either fall out or decay early.

Albrecht has reported cases where the canines and molars being erupted at birth were retained for thirty years and upward. Here there would probably be non-development of the second dental follicles.

He explains the occurrence of a supposed third set by the fact that a tooth may be retained till old age and then appear from atrophy of the jaws.

Abnormal position.—This may be due to development of dental follicles in an abnormal position, *e. g.*, in the ramus or condyle of the lower jaw, the middle of the hard palate or nasal fossal; or *obstruction* due to milk teeth being too firmly set or the cavity ossifying over the second tooth after removal of the first. Obstruction may also be caused by narrowness or shortness of the alveolar margin or abnormal direction of the whole alveolar process, the normal direction being either vertical or inclining slightly inwards, the upper set overlapping those of the under jaw. The narrowing of the margin may be caused in rickety children by the pressure between the labial muscles and the tongue.

Anomalies in size may occur, the single teeth may be over-developed, or three of them may have a continuous outer coating of cement and enamel (seen chiefly in the incisors).

The case which I will record to-night belongs to the class with early eruption. Dr. J. W. Ballantyne, of Edinburgh, in a paper read before the Edinburgh Obstetrical Society in March, 1896, on "Congenital Teeth, with three illustrated cases," deals very thoroughly with these anomalies. In the first described by Dr. A. M. Vargas, of the University of Barcelona, there was an elevated outgrowth from the margin of the lower jaw, which before operation was thought to be a congenital neoplasm, but, being cut into, it proved to be a premature tooth enclosed in an extra alveolar sac.

It was covered with mucous membrane and an inner layer of very vascular connective tissue and was movable at the base. There was no root.

In the second case occurring in his own practice, two bright white, thin, slightly-movable teeth (lower central incisors) were present at birth, which the mother said were absorbed, but which Dr. Ballantyne thinks probably dropped out. There was a tubercular family history. They were replaced at seven months by two new teeth.

The third case is described by Dr. R. C. Buist:

The two lower central incisors at birth projected above the gum, the right two mms., the left less. They were movable backward and forward. The gum at the roots was swollen and everted before and behind, this becoming less in a few days when the teeth were more firmly held. They both came out during the first month and it was stated that they felt like gristle. They have not been replaced. Dentition was otherwise normal.

I might now describe the case which occurred in my practice a year ago, the two lower central incisors being present at birth. When two days old the boy wounded his mother's nipple, an abscess resulting in spite of antiseptic treatment and the use of a shield.

Strumpbell advises removal if the teeth are loose. In this case the teeth were not drawn for certain reasons. They were set in a movable, hinge-like process of the alveolus raised above the level of the gum about one-third of an inch. Below the hinge and at the symphisis there was an exostosis, which has since disappeared.

A few days after birth the child developed a pempigous eruption and at six weeks snuffles and a papular syphilide.

The father had contracted syphilis twelve years before and had been under treatment with iodides and mercury for two years at

that time. The first child, born ten years ago, died from congenital syphilis and there have been none since.

To return, in the meantime the teeth had become firmly set, and the hinge had lost both its elevation and mobility. Shortly afterward the crowns softened, losing their lime salts and leaving the pulp cavities exposed as they are at present level with the gum. We will probably scoop out and fill with gutta percha or cement. No other teeth have since arrived. I sent an account of this case to Dr. Ballantyne, whose reply was most courteous and was as follows:

DEAR DR. OLDRIGHT,—The editor of *The Edinburgh Medical Journal* sent on to me your record of an interesting case of congenital teeth. Allow me to thank you for this record which contains several new features. I find the after history of these teeth when they are not removed at once is rather obscure. In some cases they are certainly replaced by milk teeth and are then really supernumerary as well as previous, but in other cases they seem to be the only milk teeth which the infant has. The exostosis is interesting, but its meaning is far from clear. Since I wrote my paper I have had several records sent me, and two of these I have embodied in an article on "Congenital Teeth" in the forthcoming supplementary volume of "Keating's Cyclopædia of Diseases of Children." In one of these the child presented by the face, and the teeth were diagnosed before delivery—a truly unique circumstance, I suppose. I send you a reprint of my paper, also one of another curious case of abnormal dental development. I am specially interested in all congenital anomalies and shall always be glad to hear from you regarding such. The syphilis may have had to do with the early decay of the congenital teeth in your little patient, but I scarcely think it could be regarded as the cause.

Believe me, yours faithfully,

J. W. BALLANTYNE.

24 Melville street, Edinburgh, Feb. 7th, 1898.

Dr. Ballantyne very kindly sent me his monograph from which I will quote his conclusions:

(1) Congenital teeth form a rare anomaly, but one which has long been known both to the profession and to the public.

(2) Their presence has often an ill effect upon lactation, partly on account of imperfect closure of the infant's mouth and partly by injury to the mother's nipple; sublingual ulceration may also result, and infantile diarrhœa and atrophy are more distant consequences. Sometimes, however, symptoms are altogether absent.

(3) Congenital teeth have probably little or no prognostic significance as regards the bodily or mental vigor of the infant carrying them.

(4) The teeth usually met with are lower incisors, but sometimes upper incisors may be seen, and very rarely molars of either upper or lower jaw. Other facial or buccal malformations may occasionally be met with.

(5) They are caused by premature occurrence of the processes which normally lead to the cutting of the milk teeth; in a few cases it would seem that the anomaly is due to a true ectopia of the dental follicle and its contained tooth.

(6) In a few cases a hereditary history has been established.

(7) As congenital teeth are usually incomplete and ill-developed, and likely to be more an inconvenience than an advantage to the infant, they are best removed soon after birth, an operation which can be easily, and, except in very rare instances, safely, performed.

(8) The occurrence of premature teeth in certain well-known historical personages is an interesting fact, the importance of which has been much exaggerated.

Under pathogenesis he gives as the predisposing causes:

(1) Ectopia.

(2) Imperfect development of tooth and absence of fang to fix it deeply.

(3) Too early deposit of salts.

(4) Atrophic state of gum.

(5) Intra-follicular inflammation and ulceration of gum.

Under frequency of occurrence, Paris Maternity, out of 17,578 new-born infants, 1858-1868, three had teeth—one in 6,000.

In 20,000 births Blot had not seen an instance.

Besnier and Gueniot regarded them as very common.

The truth lies between the two extremes. In Dr. Ballantyne's paper he has gathered together from literature some seventy cases, and he says that doubtless not a few have escaped notice.

I will give part of the doctor's historical section in which he names the famous personages, Richard III., Louis XIV., Richelieu, Mirabeau, and Mazarin. Shakespeare, in King Richard III., Act II., Sc. 4, makes the Duchess of York say:

"Marry, they say my uncle grew so fast
That he could gnaw a crust at two hours old;
'Twas full two years ere I could get a tooth."

Also in Act IV., Sc. 4, of the same play Queen Margaret says:

"That dog that had his teeth before his eyes."

And in King Henry the Sixth, Part III. Act V., Sc. 6, the following words occur:

"Teeth hadst thou in thy head when thou wast born,
To signify, thou cam'st to bite the world."

And Richard himself says:

"For I have often heard my mother say
I came into the world with my legs forward;

The midwife wondered and the women cried
O Jesus, bless us, he is born with teeth,
And so I was; which plainly signified
That I should snarl, and bite, and play the dog."

Mr. Mackenzie, discussing Dr. H. H. Oldright's paper, pointed out that recent study showed that there were evidences of four sets of teeth in the mammalia, a prelacteal and first permanent set being indicated by slight traces of tooth gums. It was thought that supernumerary sets of teeth were ataccolic in character.

Dr. Rudolf, discussing Dr. H. H. Oldright's paper, asked if Dr. Oldright had heard of congenital teeth being lucky.

Dr. Pepler spoke of a girl of 21 years with only one set of teeth.

Dr. Oldright replied.

Dr. Oldright also reported a case of tubercular infection of the inguinal and pelvic glands from a cut in the sole of the foot.

Patient was twelve years of age, came under his care two and a-half months after receiving a wound from a nail in the sole of the right foot. The glands in Scarpa's triangle were enlarged and inflamed. One had previously been opened, another contained pus.

The wound in the foot had not healed and showed a granular ulcerating surface about one-third of an inch in diameter. Counslips from this showed staphylococci. There was also an enlarged gland lying external to the external iliac artery, about an inch above Poupart's ligament.

Sections of the glands after removal confirmed the diagnosis of tuberculosis. The diseased pelvic glands were removed later and proved to be tuberculous also.

The speaker believed this to be an instance of true infection by entrance of tubercle baccilli at the wound in the foot. It might be, however, that there had been a previous tubercular condition of the glands, and a secondary infection by pyogenic bacteria determined the suppuration. The popliteal glands were not involved.

Senn, of Chicago, thinks that the leucocytes can by their diaphe-

desis explain the occurrence of infection of glands where the sequence of involvement is in a direction against the lymph current, the leucocytes carrying the bacilli through the tissues.

Dr. Primrose referred to a case reported by him a few years ago in which tuberculous injection of the axillary glands followed vaccination in a child. The vaccination wounds remained as open ulcers, and were excised along with the glands. The history showed that the enlargement of the glands in the axilla followed the vaccination. The microscopic examination of the glands exhibited characteristic tubercle.

Dr. A. McPhedran showed a specimen of "primary carcinoma of the liver" from a man aged sixty-three. He was a farmer of good family and personal history. His health began to fail in September, 1897. He complained of failing strength and loss of appetite with indigestion. There was no pain. The asthenia became more marked. In the end of January, 1898, the prostration was marked; there was no jaundice, the stools were of normal color, the urine contained no bile pigment. The stomach was dilated and contained ten ounces of grumous remnants of food. The temperature was slightly but irregularly elevated. The liver was uniformly large, reaching two finger-breadths below the costal margin, very tender, markedly indurated and minutely nodular. A few days before death (February 16) he became suddenly deeply jaundiced.

Autopsy: Liver large, very hard, nodular, the largest nodule at the posterior border. Some of the glands behind the liver were somewhat enlarged. The other abdominal organs were unaffected.

Dr. Peters discussing Dr. McPhedran's paper said: While theoretically it is doubtless quite possible that there may be a primary carcinoma of the liver, it is well known that a primary focus of very small dimensions in any part of the portal circulation may give rise to secondary growths in the liver, and consequently a most thorough search of the whole area tributary to the liver should be made before any carcinoma of the liver should be classed as primary in character.

Dr. Anderson also discussed the case.

Dr. Pepler referred to a similar case.

Dr. McPhedran replied.

Dr. Peters reported a case of spindle-celled sarcoma of the thigh bone, with microscopic preparations.

Amputation at the hip-joint was performed, and there has been, so far, no recurrence (seven months after operation).

L. H., æt 11. Admitted to V. H. S. C., August 18, 1897. Good family history. No tubercle or syphilis in family.

There was no history of injury. Four months before admission she complained of pain in the left leg. Swelling about the upper third of the thigh was noticed about the same time. She lost flesh rapidly and suffered a great deal. At time of admission she was unable to walk.

On examination a fusiform tumor about 6 inches in length was found extending downwards from the middle of the left femur. The right thigh measured 9¾ inches, and the left 13 inches in circumference over the tumor. There was no enlargement of the inguinal glands, but atrophy of the muscles of the left side was marked.

The sarcoma was found to have infiltrated the muscles somewhat extensively. It had apparently commenced beneath the periosteum, and had spread so as to entirely surround the bone, and to project about equally from all aspects of its circumference. The bone was eaten away on the surface but not to such an extent as to materially weaken it.

On microscopic examination the tumor was found to be a large spindle-celled sarcoma.

A committee, consisting of the president, Dr. A. McPhedran, and the recording secretary, was then appointed to act with the committees from the other medical societies *re* the formation of an Academy of Medicine.

The meeting then adjourned.

H. C. PARSONS,
Recording Secretary.

Correspondence.

To the Editor of THE CANADIAN PRACTITIONER :

DEAR SIR,—The many articles that have been written concerning the Victorian Order of Nurses have induced me to give you the plan of caring for the sick poor that is now being successfully carried on in our town. A plan similar to the Victorian Order was tried before the present one was adopted. A trained nurse was hired to do missionary work *a la* Victorian Order for a year, and it proved a lamentable failure. The present system has been followed for more than a year and there is no desire to give it up. The beginning of the present system is due to Mr. J. Penman. In consultation with him in regard to the matter of nursing the sick poor, after a trial of the so-called district or missionary nursing, we visited several of the women in our town accustomed to go out nursing, women who are not known as regularly trained nurses or graduates, but those who have spent many years in nursing the sick, and especially labor cases, and as every physician knows they are the equal, if not the superior, of the trained nurse in caring for the newly-born child. I think you will find such women in every town, and in every ward in a city, women who besides a good general knowledge, have mastered fairly well the care of the household generally, and who do not think it menial work to have a house put in order, who can cook a good plain meal, and who can wash and iron and even scrub. We have such women in our town. They have been tried and are not found wanting. One of them is under a regular engagement. If employed for the whole month is paid in full, if not employed, gets a retainer. She is allowed to do other work if there are no sick poor requiring her services. If engaged there are other women on her list who seem glad to assist at any time. There are always a few women of the sort I have mentioned who are glad to be employed, if only for a few days or a week at a time. So far we have had no difficulty in regard to this matter.

I shall mention one case to show how well the system is working. Last summer Mrs. B. was taken ill with chorea, pregnant six months. Her husband and two little children made up the family. The house was a scene of destitution too painful to describe. The disease developed so rapidly that it looked like prejudicing her case to send her to the nearest hospital, seven miles away. Mrs. S., the nurse, was sent to the family. Kind people supplied immediate wants, and only those who know how serious some choreic cases are will understand the situation. It was impossible to keep the woman from injuring herself, so violent were the jerkings. With the help of the nurse, and a little extra assistance, the poor woman was safely carried to full time and gave birth to as healthy a looking child as one ordinarily sees. For several days when the disease was at its height I fully expected labor would require to be induced. Had we not had this nursing system the poor woman would have gone to the hospital at some risk. The children would have been cared for by the Children's Aid Society. And the poor husband! well, I don't know what he would have done. At the time of his wife's seizure he had just obtained work. This woman is now in very good health and the family are all together. Our nurse as a rule is not always so severely taxed as with this case. In fact some months she has no poor nursing, but it is a relief to think if a case arises it will be cared for, thanks to the philanthropic spirit of Mr. Penman. Now I feel assured that, if there are women of the kind I have mentioned in every town, in every municipality, there are philanthropic spirits also. These women are on the ground. When not engaged they have the enjoyment of their own homes. I need not, Mr. Editor, make further comment on what has been rendered self-evident, that the homes of our sick poor are made clean and habitable. Who would dare to look upon such work as menial? Does not the surgeon invade the abdominal cavity, ofttimes in a most foul, septic condition, of the poorest of the poor, as has been known, at the risk of his life, without considering his work ended until every vestige of septic matter has been removed? Why not care for the houses of the sick poor? But I did not intend to make any comments.

Yours faithfully,

W. BURT.

PARIS, April 20th, 1898.

Editor PRACTITIONER:

DEAR SIR,—Your editorial in the April issue of your journal relative to the medical department of our military system is right, and it is high time a re-organization took place. While the other departments have advanced we are in the same old rut that existed twenty years ago. I think, sir, we have now a Director-General, Surgeon Lt.-Col. Neilson, who will do all he can to promote the efficiency of the medical staff. There is no doubt that we have been severely neglected in the past, and, now, let us rise in our might, and urge the Government to redress our wrongs; and, by doing so, we may strengthen the hands of our efficient Minister of Militia, Hon. Dr. Borden. I would suggest that an organization, composed of the medical officers of all the military corps in Canada, be formed. All matters pertaining to our department could be discussed; and, if necessary, our grievances might be embodied in a set of resolutions which could be presented to the Minister of Militia. I know we have doctors in the House of Commons, members of the medical staff, who will assist us with all their might. One complaint I have is this, viz., that the average surgeon-major does not know what kind of a military outfit to buy, and, furthermore, there seems to be no one to inform him; and yet he may be subjected to a reprimand from the D.O.C. for not appearing properly dressed at the military camp. I think there should be two surgeons to a battalion, and I would encourage the formation of ambulance corps as much as possible, and not do away with existing ones. I would like the question of rank (relative or substantive) thoroughly sifted and settled, as I cannot understand it.

Yours truly,

SURGEON-MAJOR.

THE TREATMENT OF INEBRIATES.

To the Editor of THE CANADIAN PRACTITIONER:

SIR,—During the last ten or twelve months a persistent attempt has been made with a view to the introduction of proprietary remedies for the medical treatment of the inebriate inmates of the Central Prison and the county gaols of the Province.

Strong pressure has been brought to bear on the Ontario Government, and an attempt has been made to secure the influence and co-operation of the Prisoners' Aid Association to this end. Largely as a result of this agitation I was commissioned at the January

monthly meeting of the latter association to visit Canadian and American inebriate hospitals and to interview specialists in inebriety with a view to the formulating of a well-digested, practical scheme, to be submitted to the Government, covering the whole question of the treatment of our inebriate population. In executing this commission I visited in Canada the Homewood Retreat, Guelph, the Lakehurst Sanitarium, Oakville, and the Keeley Institute, Toronto; while in the United States I visited the Washington Home, the Woman's Home, and the Baker Gold Cure, Boston, the Hospital for Dipsomaniacs and Inebriates, Foxboro, and the Walnut Lodge Sanitarium, Hartford, Conn. I also had an interview with Dr. L. D. Mason, of Brooklyn, a well-known specialist and son of the late Dr. Mason, one of the pioneers in the study and cure of inebriety. In the further execution of my commission I availed myself of all the literature procurable, including the last edition of "Inebriety, or Narcomania," by Dr. Norman Kerr (720 pages), and the back volumes of *The Quarterly Journal of Inebriety*. My report has been presented to the Prisoners' Aid Association; but, as its consideration has been deferred until next meeting, it has not as yet been forwarded to the Government. The following is a summary of my recommendations, which are partly the result of information recently obtained, and partly the result of study extending over a period of several years:

"(1) The appointment by the Lieutenant-Governor-in-Council of an Inspector of Inebriate Institutions. This inspector should be a qualified medical practitioner who has made the medical treatment of inebriety a special study. (2) The inspector should organize in the city of Toronto an hospital for the medical treatment of pauper male inebriates of the more hopeful class, and in the other cities of the Province an inebriate department in the existing general hospitals, more especially for pauper male inebriates. (3) An industrial reformatory should be established on the farm-colony plan for the custody of the more hopeless or incorrigible class of male drunkards, and where they should be detained on indeterminate sentences. (4) Pending the opening of an inebriate hospital in Toronto, it would be both humane and in the interests of prison reform to give special medical treatment to the dipsomaniac inmates of the Central Prison. (5) For the more hopeful class of female inebriates, cottage homes (or utilizing existing homes) are recommended for special medical treatment. (6) For the incorrigible class of female drunkards full two-year sentences to the Mercer Reformatory for Women are recommended. (7) In the adoption of scientific medi-

cal treatment the Norman Kerr-Crothers system, or general plan, is recommended. In the interests of science and good morals proprietary remedies should not be used. (8) The adoption of the 'probation system' for giving a helping hand to patients subsequent to treatment of inebriety."

About two and a half years ago a deputation from the Ontario Medical Association waited upon the Ontario Government for the purpose of urging the establishment of an industrial reformatory in the province for habitual drunkards. Petitions have also been sent to the Government by the Ontario W.C.T.U., by the Prisoners' Aid Association, and by other public bodies with regard to the great need of a reformatory for inebriates; but the Government declines to take action, although some members of the Government admit that something should be done for the unfortunate class referred to.

The Ontario Medical Association has also asked the Ontario Government to make provision for the custodial treatment of epileptics. I would suggest, in this connection, that it would be both a wise and an economical arrangement to provide a large farm-colony for both classes under one management, the epileptics and the inebriates being provided for either on the same or on an adjoining farm-colony. Many of the inebriates could be utilized as farm helps, nurses, guards, etc., on the farm-colony for epileptics.

It is self-evident, it seems to me, that by carrying out the scheme herein formulated with regard to the treatment of male and female inebriates the cost would be reduced to a minimum, and the number of chronic inebriates remaining to be provided for at the Mercer Reformatory for Women or on the farm-colony plan for men would be reduced to small proportions.

With regard to the results of medical treatment, I find that from 80 to 90 per cent. remain sober for periods varying from a few weeks to several months, and that from 30 to 50 per cent. may be cured by care and judicious after-treatment. There is a system in operation in Massachusetts whereby drunkards, instead of being imprisoned, are placed under the supervision of an officer called a probation officer. My proposition is to utilize this system for the purpose of giving a helping hand to patients subsequent to treatment for inebriety. Much good can be accomplished in the cause of temperance by finding employment for reformed inebriates. It is too much to expect that a reformed drunkard will remain long temperate if he fails to find employment. Hence the necessity of making the necessary provision for meeting this felt want.

It will be observed that in my recommendations I make mention of what I call the "Norman Kerr-Crothers" system of medical treatment. By this I mean medical treatment on sound principles of therapeutics such as is given in Dr. Norman Kerr's treatise on inebriety, and as endorsed by Dr. T. D. Crothers in his article on "Alcoholism" in Hare's Practical Therapeutics.

If the scheme as here outlined should commend itself to the best judgment of the profession in Ontario I would suggest that action be taken in this important matter at the approaching annual meeting of the Ontario Medical Association. Inebriety is now recognized as a disease, and as such has a claim upon the profession fully equal to that of insanity, tuberculosis or epilepsy. Allow me to bespeak, Mr. Editor, the weight of your influence and that of THE PRACTITIONER in the direction indicated.

Yours truly, A. M. ROSEBRUGH, M.D.

Toronto, April 30, 1898.

Book Reviews.

Books received.

THE TREATMENT OF SARCOMA AND CARCINOMA BY INJECTION OF MIXED TOXINS. By C. Mansell Moullen, M.D., Oxon., F.R.C.S, Surgeon and Lecturer on Surgery at the London Hospital, Examiner of Surgery at the University of Oxford, etc., etc. Price 3s. 6d., ($1.) London: John Bale Sons & Davidson, Ltd., 85-89 Great Litchfield street—Oxford street, W.

AN AMERICAN TEXT-BOOK OF GENITO-URINARY AND SKIN DISEASES. Edited by L. Bolton Bangs, M.D., late Professor of Genito-Urinary and Venereal Diseases, New York Post-Graduate Medical School and Hospital; and William A. Hardaway, M.D., Professor of Diseases of the Skin, Missouri Medical College. Octavo volume of over 1,200 pages, with 300 illustrations in the text, and 20 full-page colored plates. Prices: Cloth, $7 net; sheep or half morocco, $8 net. Philadelphia: W. B. Saunders; Canadian agents, J. A. Carnech & Co., 413 Parliament street, Toronto.

MOORE'S ORTHOPŒDIC SURGERY. A Manual of Orthopœdic Surgery. By James E. Moore, M.D., Professor of Orthopœdics and Adjunct Professor of Clinical Surgery, University of Minnesota, College of Medicine and Surgery. 8vo., 356 pages, handsomely illustrated. Cloth, $2.50 net. Philadelphia: W. B. Saunders. Canadian agents: J. A. Carnech & Co., 413 Parliament street, Toronto.

CHAPIN ON INSANITY. A Compendium of Insanity. By John B. Chapin, M.D., LL.D., Physician-in-Chief, Pennsylvania Hospital for the Insane; late Physician-Superintendent of the Willard State Hospital, New York, etc. 12mo, 234 pages, illustrated. Philadelphia: W. B. Saunders. Canadian agents: J. A. Carnech & Co., 413 Parliament street, Toronto.

KEEN ON THE SURGERY OF TYPHOID FEVER. The Surgical Complications and Sequels of Typhoid Fever. By Wm. W. Keen, M.D., LL.D., Professor of the Principles of Surgery, and of Clinical Surgery, Jefferson Medical College, Philadelphia. Octavo volume of 400 pages. Cloth, $3 net. Philadelphia: W. B. Saunders. Canadian agents: J. A. Carnech & Co., 413 Parliament street, Toronto.

VAN VALZAH AND NISBET'S DISEASES OF THE STOMACH. Diseases of the Stomach. By William W. Van Valzah, M.D., Professor of General Medicine and Diseases of the Digestive System and the Blood, New York Polyclinic; and J. Douglas Nisbet, M.D., Adjunct Professor of General Medicine and Diseases of the Digestive System and the Blood, New York Polyclinic. Octavo volume of 700 pages, illustrated. Cloth, $3 50 net. Philadelphia: W. B. Saunders. Canadian agents, J. A. Carnech & Co., 413 Parliament street, Toronto.

SAJOUS'S ANNUAL AND ANALYTICAL CYCLOPÆDIA OF PRACTICAL MEDICINE. Subscription for entire series only. Six volumes—one every six months. Cloth, $5.00; half Russia, $6.00. Monthly supplements sent free during the three years. The F. A. Davis Company, publishers, Philadelphia.

It is impossible to review such a work as this, for the principal reason that it is a review of all the medical literature of the day. The departure is not exactly a new one, but a great advance on a very useful work, "Sajous's Annual." The articles in the first volume are from "Abdominal Injuries" to "Bright's Disease," and are most comprehensive indeed. No one need be behind in the very latest advances if he possesses this work. The connection is to be kept up by monthly supplements, which will carry all current literature to date.

Dr. Sajous—whose experience, all will admit, has been sufficient to constitute him a person qualified to judge—believes it is absolutely feasible to combine the features of a text-book and of a work like "Sajous's Annual" in one system. His idea has been submitted to many eminent medical writers, and has, in every instance, received their unqualified approval. Likewise a large number of busy, general practitioners, who not only feel the financial tax for medical works quite severely, but find that the possession of a large reference library only entails a corresponding amount of labor in using it, look upon Dr. Sajous's plan with particular favor.

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The F. A. Davis Co. are maintaining their very enviable reputation in the present volume, and we know it will be maintained throughout the series.

Medical Items.

THE freedom of the city of Edinburgh will be conferred on Lord Lister on June 15th.

DR. GEORGE S. RENNIE, of Hamilton, who was seriously injured April 7th, through a runaway accident, has quite recovered.

DR. NORMAN GWYN, one of the resident physicians of Johns Hopkins Hospital, has obtained leave of absence for six months to study in Freiburg.

DRS. JOHN AMYOT AND WM. GOLDIE, of Toronto, left for Europe May 13. They expect to go first to London, and after remaining there for a time will cross to the Continent and spend some months in Paris and Vienna.

DR. T. B. FUTCHER, Associate in Medicine, Johns Hopkins Hospital, has gone to Strasburg for a period of six months' study. On his return, Oct. 1st, he will succeed Dr. Thayer as first assistant in the medical clinic of the Johns Hopkins Hospital.

CLINICAL RECORDS (20).—A hedge doctor (a quack) in Ireland was being examined at an inquest on his treatment of a patient who had died. "I gave him ipecacuanha," he said. "You might just as well have given him the aurora borealis," said the coroner. "Indade, yer honor, and that's just what I should have given him next, if he hadn't died."

A short time ago an old lady went on board Nelson's flagship, the Victory. The different objects of interest were duly shown to her, and, on reaching the spot where the great naval hero was wounded (which is marked by a raised brass plate), the officer remarked to her: "Here Nelson fell!" "And no wonder!" exclaimed the old lady; "I nearly fell there myself!"

A NEW SYSTEM OF SMOKELESS COAL FIRING.—A method of burning coal without the production of smoke was recently the subject of trial at the Grand Junction Waterworks pumping station at Hampton. The method aims at producing complete and instantaneous combustion by surrounding each particle of coal with an adequate supply of oxygen. For this purpose the coal is finely pulverized and carried into the furnace by means of the draught of the chimney. The ordinary arrange-

ments of the furnace are dispensed with, that is, the grate and firebars are removed, and in place of the door is fitted an iron plate through which passes a tube conveying air to the fire. As this current of air enters the furnace it meets a falling stream of pulverized coal and carries it into the furnace, where it is instantly consumed. The system is known as the Carl Wegener system.

ONTARIO MEDICAL ASSOCIATION.—Preliminary Programme of Papers, 1898.—"Syphilitic Cirrhosis": Jas. Bell, Montreal. "Pancreatitis, from a Surgical Standpoint": J. G. Adams, Montreal. Discussion in Medicine, "Relation of Excretion to Disease": H. A. MacCallum, London; H. B. Anderson, Toronto. Discussion in Surgery, "Treatment of Fracture of the Skull": Geo. A. Peters, Toronto; Geo. S. Rennie, Hamilton. Discussion in Gynæcology, "Carcinoma of the Uterus": G. K. Holmes, Chatham; J. W. S. McCullough, Alliston; H. S. Griffin, Hamilton. "Tubercular Meningitis": R. J. Dwyer, Toronto. Alex. Primrose, Toronto. Albert A. MacDonald, Toronto. "The Injurious Effects of our Over-wrought School System on the Health of Public and High School Pupils": R. Ferguson, London. "Immunity": J. J. MacKenzie. "The Effects of the Climate of our Canadian North-west on Tubercular Patients": Peter H. Bryce, Toronto. "Endomentistes, with Erosions of the Os": G. F. W. Ross, Toronto. "The Early Removal of Tubercular or Necrotic Areas": H. H. Oldright, Toronto, "The Traumatism of Labor": C. B. Oliver, Weston. "Rheumatoid Arthritis in Children,—Exhibition of Patient": W. B. Thistle, Toronto. "When Shou'd we Operate?" illustrated by cases and specimens · Wm. Oldright, Toronto. "My Experience with Diphtheria during the Fall of 1897": W. Doan, Harrietsville, Ont. "Hyper-resonance of the Chest—a Premonitory Symptom of Tuberculosis of the Lung": W. C. Heggie, Toronto. "The Medical and Surgical Treatment of the Insane": A. T. Hobbs, London. "Cretinism in Ontario": A. McPhedran, Toronto. "Some Details in Antiseptic Surgery": N. A. Powell. "Puerperal Complications—Cases in Practice": H. D. Livingstone, Rockwood. "Experiences with New Remedies": G. S. Ryerson. "Vicarious Urination, with Case": A. T. Rice, Woodstock. A. McKinnon, Guelph. "A Brief Sketch of the Nervous System, of its Liability to Injury and some of its Diseases": S. Byron Newman, Detroit. "The Various Operative Methods of Dealing with Eyes lost Through Injury or Disease": G. H. Burnham, Toronto. "Toxæmicæ of Pregnancy": C. J. D. Hastings, Toronto. "Hypo and Hyper-respiration in Pulmonary Tuberculosis": Edward Playter, Ottawa. "Infant Diet": W. J. Greig, Toronto. "Remarks on the Treatment of Clubfoot, based on the Personal Observation of 243 Cases": B. E. MacKenzie. Exhibition of a machine for manufacturing plaster paris bandages: H. P. Galloway.

OBITUARY.

SALOMEN STRICKER, M.D.—Professor Stricker (Pathology), of the University of Vienna, died April 4th, aged 64.

EDWARD COTTERELL, F R.C.S. ENG.—Mr. Cotterell, of London, England, died April 5th, of pneumonia, aged 41.

LLEWELLYN BROCK, M.D.—Dr. Llewellyn Brock died at Lion's Head, Bruce County, April 22, aged 34. The cause of death was pneumonia, his illness lasting only four days. He received his medical education in Trinity Medical College, Toronto, and graduated in 1886. He was the eldest son of Dr. Brock, of Guelph. The news of his death came to many of his friends before they knew anything about his sickness, and caused profound regret.

F. R. BROWN, M.D.—Dr. F. R. Brown, of Madera, California, brother of Dr. Price Brown, of Toronto, died at home April 4th, 1898, aged 61, after an illness of four days, from septicæmia due to inoculation while operating on a gangrenous patient at the county hospital. He was born in England, but at the age of eighteen came to western Canada with his parents. He lived for five years in Ontario, and then commenced the study of medicine at Ann Arbor, Mich., where he graduated in 1869. He immediately settled in California, and soon achieved signal success. The Madera *Mercury*, after referring to his illness and death, says: "By his genial manners, his uprightness and honesty, Dr. Brown endeared himself to all with whom he came in contact. He was public-spirited and enterprising, and by his death Madera has suffered an irreparable loss."